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Mental Health is Health.

Milwaukee County Behavioral Health Division
Replacement Hospital Program Study

Final Report: Appendices Volume 2
7.27.2015

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Milwaukee County Behavioral Health Department
Replacement Hospital Program Study
Author: Francis Murdock Pitts FAIA, FACHA
July 27, 2015

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Appendix A - List of Prior Studies

Milwaukee County Mental Health Source Material

18-Feb-14

Publication Date	Author	Title
2004	Mental Health Task Force	A Critical Juncture: AS Report to the Community
2009	The Management Group, Inc.	Wisconsin Public Mental Health and Substance Abuse Infrastructure Study
2013	Milwaukee County	Milwaukee County Executive's 2013, 2014 and 2015 Budgets. DHS Behavioral Health Division
2014	Human Services Research Institute,	Milwaukee County Service Capacity Report
2014	Milwaukee County	Mental Health Redesign Working Forum. Milwaukee County Mental Health Redesign and Implementation Task Force
10/1/10	Human Services Research Institute	Transforming the Adult Mental Health Care Delivery System in Milwaukee County
10/4/10	Wisconsin Hospital Association Behavioral Health Task Force	Behavioral Health Task Force Whitepaper
6/3/13	Milwaukee County Mental Health Redesign Task Force	Mental Health Redesign SMART Goals: 2013-2014. Milwaukee County Mental Health Redesign Task Force
1/7/14	Milwaukee County	Community-Based Long-Term Care Options Request for Information
4/9/14	State of Wisconsin	Wisconsin Legislature/ 2013 Wisconsin Act 203
8/25/14	Milwaukee County Department of Health and Human Services	Dashboard
9/1/14	Behavioral Health Division	Progress on HRSI 2010 Report Recommendations
9/16/14	Human Services Research Institute Technical Assistance Collaborative Public Policy Forum	ANALYSIS OF ADULT BED CAPACITY For Milwaukee County Behavioral Health System
11/25/14	Deloitte Consulting	Assessment of Milwaukee County Behavioral Health System: Summary of Findings Working Paper
11/25/14	Deloitte Consulting	Appendices to Assessment of Milwaukee County Behavioral Health System: Summary of Findings Working Paper
12/8/14	Wisconsin Department of Health Services	Report on Mental Health Service Delivery in Milwaukee County 2015-2017 BHD Strategic Vision for Community Access to Recovery Services Division (CARSD) document

Appendix B - Summary of Milwaukee Clinical Services Reports

ANALYSIS OF ADULT BED CAPACITY
For Milwaukee County Behavioral Health System
September 16, 2014
Human Services Research Institute
Technical Assistance Collaborative
Public Policy Forum

We used the following formula to determine future bed need:
[# of Decreased Adult Admissions * Median Length of Stay]/365 = Number of fewer beds utilized
While this methodology provides data-driven guidance for future decisions on psychiatric bed capacity, we recommend that a trend analysis should occur for any decrease in admissions and that it is sustained for a period of at least six months before any decreases in bed capacity occur across the county.

Many issues about the behavioral health system were voiced during these discussions. Some were anecdotal and hard to substantiate, but several emerged as consistent and overlapping themes. The various themes that stakeholders identified as system issues that may affect bed need were:
☒ Insufficient community-based capacity

☒ Lack of accountability to ensure system-wide inpatient capacity
☒ Consumers with specialized or complex needs
☒ Role of Milwaukee County in providing inpatient services

Table 2. Patients with Extended Lengths of Stay at BHD

Length of Stay	Number of Patients
30 – 59 days	6
60 – 99 days	7
100 – 199 days	5
200 – 499 days	3
TOTAL	**21**

Table 3. BHD PCS Waitlist Status, Jan-July 2014

Month	Number of Days on Waitlist	BHD Actual Operating Capacity
January	0	66
February	1	66
March	0	60
April	6	60*
May	14	54
June	4	54**
July	4	66

*Census capacity was 63 for the last two days of April for which there was a waitlist.

** Census capacity for the first nine days of June was 54 beds, and between 60-66 beds for the remainder of the month.

Continued utilization of observation beds could further reduce pressure on inpatient admissions, and BHD should examine the role that observation beds should have in future system-wide inpatient bed capacity decisions.

Based on the current functional configuration of beds in the system, Tables 5 and 6 show the average open beds by acuity between January and October 2013. While the 2013 data in both tables appear to show open capacity that can accommodate admissions pressures, patient acuity or other related factors can affect the unit milieu, impacting a hospital's ability to fully utilize beds. At times, hospitals make decisions to keep bed occupancy lower to ensure a safer, more therapeutic environment; thus, vacant beds do not necessarily mean there is additional or underutilized capacity. In addition, the loss of capacity through closure of the Columbia St. Mary's unit in January 2014 has increased bed utilization in the other hospital

Table 5. Average Open Low– to Moderate-Acuity Beds by Hospital, Jan-Oct 2013

Month	Rogers	Aurora Psychiatric Hospital	Columbia St. Mary's	Wheaton-St. Francis	Aurora SLSS	TOTAL
Jan	6	6	2	2	--	16
Feb	5	6	3	2	--	16
Mar	3	6	1	2	4	16
Apr	3	4	1	1	2	11
May	4	5	4	1	4	18
Jun	3	6	2	2	4	16
Jul	2	3	2	0	3	10
Aug	2	4	1	1	1	9
Sep	5	5	1	1	1	13
Oct	6	5	3	3	3	20

Source: BHD dashboard

Generally, the inpatient system of care in Milwaukee County has relied on BHD for inpatient treatment for individuals with more symptomatology and complexity—such as individuals who are highly treatment-resistant or are exhibiting assaultive and aggressive behavior—and those who are more likely to have a longer length of stay. Aurora Psychiatric Hospital did open a higher acuity unit in 2013, but continues to refer the highest acuity patients to BHD. Those with low/moderate acuity —individuals who are more likely to benefit from shorter inpatient length of stay and tend to present with fewer risks—tend to be admitted to private hospitals. Absent an organized approach to the county's inpatient system of care, this issue places pressure on BHD's bed capacity and utilization.

It is unrealistic to think that there can be dedicated beds designed to meet the needs of all possible patient diagnoses or characteristics. Rather, individual hospitals (including state, county, private, and general acute) each should maintain or contract for clinical capacity to meet the unique, diverse needs of individuals who require access to different types of specialty care on units (for example, general medical practitioners, addiction specialists, and behaviorists). For private hospitals to work

with more complex patients, they will likely need to increase professional and para-professional expertise and coverage to ensure safe, therapeutic environments.

Figure 5 illustrates the greater reliance of the private hospitals on managed care (including Medicaid HMO); in contrast, BHD bears a greater responsibility for individuals who are without insurance or eligible payer sources. Notably, 57% of admissions to Rogers had private insurance compared to 9% at BHD. Medicaid was the most common payer source of BHD patients: 32% had Medicaid HMO and 22% Medicaid fee for service (T19).29

In Milwaukee County, the lack of such clear guidelines to govern psychiatric inpatient bed capacity and responsibility is problematic. For example, the ability of individual providers to open and close beds unilaterally and on short notice—and sometimes solely in response to psychiatrist vacations or absences—can negatively impact overall system capacity in ways that cannot be anticipated and effectively addressed by other providers. The lack of formal system criteria with regard to admissions is also problematic, as individual providers can establish their own criteria that are determined by variables such as patient acuity or payer factors. Payer factors may become an increasing concern as private hospitals engage in managed care and create accountable care networks that will drive bed capacity.

The role of the State of Wisconsin also must be clarified. For example, like the County, the State is also considering strategies to reduce census in its facilities at Mendota and Winnebago. While such action is consistent with national efforts from economic and community integration perspectives, it could be detrimental to BHD's downsizing efforts; an inability to send additional consumers to state hospitals could preclude an important option for certain patients served by Milwaukee County.

As of August 2014, there were 38 individuals in Hilltop and fewer than 35 in Rehab Central. Both facilities have 24-hour supervision and are highly structured environments with comprehensive treatment and supports. As a result, it is reported by BHD that there has been low utilization of psychiatric inpatient beds by the Hilltop and Rehab Central residents. As residents are moved into community-based settings, however, there is some possibility that there will be an increase in psychiatric inpatient utilization if services do not meet individuals' needs, creating a new pressure point. In addition, individuals who otherwise would have been admitted to either of these facilities could also remain on BHD inpatient units for a longer period of time if sufficient community-based options do not exist.

According to BHD, two former residents were admitted to BHD once, and another individual was admitted twice, since downsizing of the two facilities began. While there have been few admissions to BHD of former residents of Rehab Central and Hilltop since downsizing began, the number of inpatient bed days consumed is long, with one presently exceeding 425 days. Over time, it is likely that some of these individuals, and individuals with similar needs, will need inpatient treatment, and BHD should track this issue to understand the impact to bed demand and the need to deliver more enhanced services to those individuals in community settings.

Recommendations
6.1 Short-Term Demand and Need for Adult Psychiatric Beds

Recommendation: Based on the current capacity and composition of the overall adult mental health system in Milwaukee, adult inpatient bed capacity should be in the range of 167 to 188 beds.

This does not suggest that the 167 to 188 bed range needed now is ideal for the longer term. Instead, it reflects the need based on the current capability and capacity of Milwaukee County's overall behavioral health system. We found that new investments made in mobile response, for example, have helped lessen the pressure on PCS and inpatient demand at BHD; however, these investments have not significantly improved access to community-based services. Ideally, Milwaukee County and the new Mental Health Board should emphasize the development of the types of accessible, community-based services that could reduce the demand for inpatient beds.

6.2 Type and Configuration of Beds

Recommendation: Using the upper range of beds needed in the system to meet demand (188 beds), 54 to 60 adult inpatient beds should be maintained to serve high-acuity and/or indigent patients and roughly 128 to 134 beds should be maintained to serve low– to moderate-acuity patients.

6.3 Planning for Future Bed Capacity

Recommendation: BHD should expand community-based services that have been shown to promote recovery and decrease the need for hospitalization. Future decreases in bed capacity should be based on inpatient and community-based services metrics that demonstrate a sustainable decrease in demand for inpatient beds.

Recommendation: The private hospitals should continue to increase their role in meeting the psychiatric inpatient needs of Milwaukee County residents. BHD should collaborate with and assist the private hospitals to successfully treat individuals with complex situations and seamlessly facilitate their discharge back into the community.

We also think that much of the inpatient care provided at BHD can be provided by the private hospitals, especially if the community-based services are increased and providers are equipped to work with consumers who have more challenging behaviors. It is likely there will still be a need for beds to serve a higher level of acuity, but BHD does not necessarily have to be the entity to operate those beds. This decision ideally should be determined by which party can provide those beds in the most cost-effective and clinically proficient manner.

The private hospitals have expressed concerns about their ability and willingness to assume this responsibility, including finding appropriate community settings to which patients can be discharged and additional financial risks they would incur for delayed discharges if community resources are unavailable or nonexistent. The County, and possibly the State, will need to consider the roles that they might play in appropriately addressing those and related concerns. Another alternative would be for the State to assume the responsibility for those limited instances when higher-acuity beds for the most complex patients are needed.

Given that the private hospitals currently handle approximately 85% of all admissions to inpatient care, however, a major consideration for the longer term is at what point it becomes economically inefficient for the County to continue to provide care at the Mental Health Complex. BHD could

negotiate a rate to pay for Medicaid-eligible or uninsured individuals at the private hospitals, or work with non-IMD private hospitals to admit more individuals with Medicaid to reduce the burden on public funds.

To accommodate a reduced but continued need for high-acuity beds and the reimbursement issues discussed throughout this report, we suggest that four scenarios exist:

☒ BHD continues to operate a smaller number of high-acuity beds at the Mental Health Complex or in a smaller facility.

☒ BHD purchases high-acuity capacity at a private hospital or hospitals.

☒ Milwaukee County residents with high-acuity, longer term needs are referred to a State-operated hospital.

☒ BHD or the State operates a regionalized facility that serves Milwaukee County residents and residents from surrounding counties who otherwise would have been referred to a State hospital for longer term care.

A separate fiscal analysis by the Public Policy Forum will be released later this year, and this analysis will be helpful in comparing the actual costs of operating beds at the Mental Health Complex against potential charges for state hospital beds.

Deloitte Working Paper
November 25, 2014

So that DHS will be able to align State and County policy to support effective treatment for the continued care for mental health and substance abuse consumers eligible for pubic/medical assistance in Milwaukee County, this paper focused on gathering consensus points within four key domains:

▪ **Inpatient Supply and Demand, Behavioral Health Division (BHD) Operations and Associated Outcomes:** Focuses on BHD's progress in right-sizing the system and its continued role in the broader County health system to serve high-acuity consumers of inpatient care.

▪ **Inpatient Diversion, specifically Crisis and Community-Based Alternatives and Associated Outcomes:** Discusses crisis and community-based initiatives that support a recovery-oriented, person-centered, trauma-informed system of care and opportunities to explore broader of these Evidence Based Practices as the County behavioral health system evolves. Includes application of principles of quality care and cost efficiency in the inpatient setting.

▪ **Transition Models:** Describes models for management of emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex.

▪ **Future Financing and Policy Implications:** Presents new delivery system options, payment/ incentives and other policy levers to support the growth of consumer services. Discusses need for a common data infrastructure and sources to measure baseline, statewide comparative and outcomes

Finding 1: BHD has developed a standard data set to measure the quality of care of inpatient services delivered at the Complex. There is a significant opportunity to enhance the collection and reporting of quality and cost outcomes data that would allow BHD to measure itself against comparable facilities and agencies. Joint Commission accreditation, specifically alignment with the Hospital-Based Inpatient Psychiatric Services (HBPIS), will accomplish this.

Additional Considerations of Finding #1

1) **Outcomes measurement strategy aligned with Hospital-Based Inpatient Services (HBIPS)**.

2) **Adjustment of utilization metrics by consumer population risk/acuity/health status.**

3) **Leverage the quality management process to measure the extent to which outcomes, such as length of stay (LOS), correlate to the level of integration between acute and community setting.**

4) **To accomplish the capture and measurement of member-level outcomes, additional effort will be required on the part of BHD for cross-program, cross-payer alignment and data availability/ exchange.**

Finding 2: The Mental Health Complex serves a unique role within the Milwaukee community by virtue of the high-acuity population it serves.

It's clear that the private hospitals rely on BHD to care for this more complex group of consumers; they in turn, have a role in serving low-moderate acuity individuals. There are processes in place to identify low-moderate individuals appropriate for care in private hospitals; yet, given the low rate of transfers of these consumers there may be opportunities to strengthen the intake and referral policies, payment incentives, etc. in order to better optimize high-acuity bed capacity at the Complex.

Additional Considerations of Finding #2:

1) **More rigorous processes and agreements with private system providers to assume responsibility for low-moderate acuity consumer Common, transparent view of consumers through a system-wide tool for consumer intake, referral and patient management across the system that eliminates subjectivity when determining eligibility and responsibility for transfer.**

2) **Explore incentives.** Multiple stakeholders noted that there are currently no financial incentives for private providers to accept a higher percentage of referrals/transfers.

3) **Initiate care coordination process with HMOs as part of initial discharge planning.**

4) **Strategic planning predicated on the Complex's continued role as a safety net behavioral health provider and in alignment with future capacity needs for high acuity consumers.**

Finding 3: It does not appear that BHD has fully explored partnerships with community Federally Qualified Health Centers and approaches to integrating care.

Finding 4: Transformation towards a trauma-informed, recovery-oriented, person-centered system is still ongoing within the operations and culture of BHD and provider agency operations.

Finding 5: Fifty-percent of the evidence based practices (EBP) were initiated on or after 2013; this indicates that provider agencies are at varying stages of fidelity with the EBP models.

Finding 6: Four models have emerged for the continued provision of inpatient care to the highest acuity population. These models are informed, in part, by the *Wisconsin Public Mental Health and Substance Abuse Infrastructure Study* (2009), options put forth in Act 203, and recently by the Analysis of Adult Inpatient Capacity (2014).

Table 8: Models for Oversight of Inpatient Facility Serving Milwaukee County Residents

Scenario	Description	Considerations
BHD maintains oversight responsibility with local operations	BHD continues to oversee and operate Psychiatric Crisis Services (ED services) and high-acuity beds at one or more smaller facilities	• BHD demonstrated outcomes in unique role serving high acuity consumers. • At same time, private hospitals have little incentive to provide care for complex consumers who are often uninsured and have long lengths of stay. • Opportunities for improving delivery of care exist. • Least structural change to current delivery of MH/SA services. • General consensus that high operating cost of the large Complex building is a barrier to efficiency. • Possibilities include securing smaller setting at different location. • Analysis of future population and funding sources requisite to inform decisions. • Possibility for BHD to contract with experienced BH Administrative System Organization to manage the Complex operations and reduce administrative burden to County.

Scenario	Description	Considerations
BHD assumes oversight responsibility with regional operations	BHD operates a regionalized facility that serves Milwaukee County residents and residents from surrounding counties who would otherwise be referred to a state hospital	• Stakeholders shared that surrounding communities may not be amenable to partnership with Milwaukee County. • Requires structural change to current delivery of MH/SA services, including contracting with surrounding counties to become payers. • Payment agreements would need to be established with surrounding counties. • Implications of IMD status and managed care reimbursement would need to be studied. • Future of operating inpatient unit at large Complex building remains an issue, but if excess capacity (resulting from reduction in high-acuity beds once dedicated to Milwaukee County residents) were to be populated by consumers from around the region, an additional revenue stream would be gained. However, this only partially addresses the sustainability of the Complex. The capital cost per patient will actually grow as portion of total cost given the infrastructure aging. For this scenario to be viable, inpatient payment rates and consistent benefit coverage policies will need to be considered.
Public-private partnership for oversight, management of operations	BHD purchases high-acuity at private hospital or hospitals	• Leverages the large scale operations of a private system, including administrative functions such as accounting and staffing as well as quality management, IT and reporting. • Private hospitals not presently equipped to care for the highest acuity consumers with forensic histories or those who current meet exclusionary criteria. • Significant investments in infrastructure and staff would be required as would financial incentives on the part of the County, State and Federal government. • Possibility exists for BHD to transfer only the most complex (forensic history/involvement, extreme risk for violence) to state hospital setting. • Requires more robust negotiation and contracting, likely payment model would need to include financial incentives. • Cultural shift and training required for law enforcement in Milwaukee County to modify crisis and ED response. • Statute requiring a designated treatment director to examine individuals within 24 hours becomes significant issue when accounting for individuals at the five private hospitals that accept involuntary individuals.

Scenario	Description	Considerations
State-managed	BHD refers all high-acuity, longer-term need individuals to other institution(s)	• Possible locations can include existing state hospitals or newly developed facilities in the region • Removing individuals from home communities is not necessarily supportive of person-centered, recovery-based, trauma-informed care. • Puts greater responsibility on private hospitals for caring for low and moderate acuity consumers and emphasizes need for more seamless and transparent referral process between BHD and private system. • Places additional pressure on state facility inpatient capacity.

Additional Consideration of Finding #6

🔲 **Cost analysis pending.** The Public Policy Form is writing a fiscal report that will analyze the actual costs to operate inpatient beds at the Complex and it will also model different scenarios for BHD in 2017, in terms of its mix of inpatient vs. community-based services. As part of that, PPF will show the cost of running a 32-bed or a 16-bed facility.

Finding 7: The Federally-mandated IMD exclusion is a critical variable in the payment of behavioral health services for Medicaid beneficiaries. It is also a primary decision point for private hospitals considering acceptance of an eligible consumer from BHD. However, given the expansion of managed care in Milwaukee County in 2014 and the opportunity to encourage enrollment in Medicaid SSI HMO, the impact on the County and its partners is potentially shifting.

Finding 8: There is consensus on the part of stakeholders around the need to explore new delivery system options, payment/incentives and other policy levers to support the growth and development of a recovery-oriented, person-centered behavioral health service delivery system.

Finding 9: Additional study is needed to quantify in total, or by program, the financial investment on the part of the county, state, federal government or private sector.

The complexity of current County behavioral health accounting and financing does not allow BHD to fully quantify in total, or by program, the financial investment on part of the County, State, Federal

government or private sector in behavioral health services. The approach limits the ability for BHD to tie expenditures directly back to programs. It also limits analysis of indirect costs and the ability for BHD to accurately predict revenue, specifically when considering growing managed care enrollment, interpretation of IMD exclusion, etc.

The Public Policy Form is writing a fiscal report that will analyze the actual costs to operate inpatient beds at the Complex and it will also model different scenarios for BHD in 2017, in terms of its mix of inpatient vs. community-based services. As part of that, PPF will show the cost of running a 32-bed or a 16-bed facility.

However, additional analysis is needed to understand the specific (quality or cost) impact of each BHD investment as it develops a strategy for future investment in crisis and community services.

Finding 10: The differences in population demographics and statutory requirements of the emergency detention process in Milwaukee County prevent the ability to compare Milwaukee to other counties around the state. Yet, there may be opportunities to explore a broader interpretation of the statute to allow for more provision of care in the least restrictive setting.

Finding 11: There is a need for the County and/or State to invest in an interoperable IT and data infrastructure to assist in behavioral system planning and performance.

Finding 12: Consumers and advocates recognize investments made by BHD to rebalance the County's behavioral health system while citing wide variation in the responsiveness, quality and recovery-orientation consumers' experience.

Bed Capacity at the Complex

There is general agreement among stakeholders the methodology used in the inpatient study for determining appropriate inpatient capacity is strong. Findings from the 2014 *Analysis of Adult Bed Capacity* determined that a range of 54-60 beds is needed to serve the highest acuity individuals and that 128-134 beds provide adequate capacity to serve low to moderate acuity individuals. BHD leadership reported agreement with the range put forth by the *Analysis of Adult Bed Capacity* Report and noted that BHD would be operating at 54 beds if not for the loss of beds at Columbia/St. Mary's and Aurora.

Of the 843 low-moderate risk/acuity individuals eligible for transfer to a private hospital from January – July 2014, only 42% were accepted by private hospitals.

Current referral patterns suggest that the private hospitals don't accept referrals of low-moderate acuity consumers (those that meet criteria) 100% of the time. So as a result, BHD uses beds for these lower risk consumers. Perhaps if there were financial incentives, standardized methods of gauging acuity across the system, etc. then the bed at the Complex would be available for the high-acuity individuals that are excluded from being referred elsewhere.

State of Wisconsin, Department of Health Services
Report on Mental Health Service Delivery in Milwaukee County
December 2014

Based on the Deloitte assessment, the Department offers four recommendations to improve the mental health service delivery system in Milwaukee County:
1. Consider statutory changes to align the emergency detention process in Milwaukee County with the process in other counties in the state.
2. Require community based crisis services prior to emergency detention.
3. Strengthen community based mental health services.
4. Implement reforms and policies that reduce inpatient utilization in Milwaukee County, and over time, transition the Milwaukee County inpatient treatment model to deliver services in the most efficient and cost effective setting.

MCMHC currently houses 18 observation beds.

The Department believes that a reduced use of the Psychiatric Crisis Services/ Admissions Center (PCS) will reduce the number of hospitalizations and would more quickly place patients into more appropriate community-based services.

The Department recommends that the state consider changes to align the emergency detention process in Milwaukee County with other Wisconsin counties.
The Department recommends that the state consider a statutory requirement that an assessment by a community based crisis program in Milwaukee be completed prior to a law enforcement officer taking an individual to the PCS at MCMHC.

It should be noted that funding pressures may also be contributing to the limited availability of crisis interventions and other community based mental health services. The report cites previous studies that have indicated a savings from a reduction in inpatient bed capacity and utilization that result from strengthening community based crisis programs would offset the cost of the investment in community programs. However, this may not consider the full legacy costs associated with maintaining a facility like MCMHC. For example, according to the report, the 2015 recommended BHD budget includes an increase of approximately $3.7 million, but roughly $2.7 million is needed to fund increased fringe benefit costs for MCMHC staff and other
costs to continue inpatient operations. If BHD is to expand community services, additional funds are likely needed to support community programs until savings can be generated through inpatient reductions, which may take several years to realize.

The Department recommends strengthening community programs through an increased focus on community crisis interventions and other crisis services, and continued expansion of other community based psychosocial services, including Comprehensive Community Services (CCS) and other Medicaid mental health programs available to counties.

The Department recommends that the Governor and Legislature implement reforms and

policies that reduce inpatient utilization in Milwaukee County, and over time, transition the Milwaukee County inpatient treatment model to deliver services in the most efficient and cost effective setting.

The report indicates general agreement among stakeholders that 54-60 adult inpatient beds are needed to serve the highest acuity adults. However, it could be argued that fewer beds would be needed if a greater emphasis were placed on crisis services and other community based programs since the current facility has a staffed operating capacity of 60 adult beds and operates beyond the scope of a true "safety net" facility.

The assessment includes a range of options for the provision of inpatient services in Milwaukee County in the future (See finding #6 and the table following finding #6). However, the Department believes there are three important decision points to be considered in planning for future inpatient needs in Milwaukee County that will drive the inpatient service model:

1) Administration – Should future inpatient services continue to be administered by BHD or should the state operate one or more facilities to provide inpatient services?

2) Service Area – Should the inpatient services be provided exclusively for Milwaukee County residents or should the inpatient services be designed to serve individuals from a larger southeastern Wisconsin region who would otherwise be referred to a state Mental Health Institute (MHI) under current law?

3) Facility type – What type of facility should be used for inpatient mental health services?

a. Existing MCMHC facility

b. Contracted or leased private hospital beds

c. 16 bed or smaller community hospitals

d. New IMD inpatient facility

Appendix C - Behavioral Health Division, Consolidated Facilities Plan: Mission and Vision

BHD-CFP Mission

To identify a consolidated, redesigned space for the people served by Milwaukee County BHD

BHD-CFP Vision

People served by Milwaukee County BHD will be served in a facility that:

1. Operates as Part of a Partnership Based Health Care System; a system that connects with a continuum of services for behavioral health, from prevention and early intervention to community based, emergency and acute services, to meet the behavioral health care needs of people in southeastern Wisconsin; a system that is person centered, recovery oriented, trauma informed, culturally intelligent, least restrictive environment, with individuals and families as essential members of the care team.

2. Reflects a Culture of Quality, Safety and Innovation; a culture that is data driven towards continuous improvement, focused on quality and safety, meeting and exceeding regulatory, accrediting, best practice standards and individual and family expectations. Technology will be implemented, created, effectively used and disseminated across the continuum of services;

3. Is Fiscally Sustainable; a physical space that will create operational efficiencies that maximize revenues and resources, and minimize overhead and unnecessary expenses. The operations within the space will meet the statutory obligations of Milwaukee County for the behavioral health services of its citizens, acting either as a provider or a purchaser of services.

4. Includes a Healthy Learning Environment; an environment that will create a positive, learning experience and a culture grounded in respectful communication, collaboration, and healthy working relationships. Support of education of clinical disciplines within BHD, inter-professional educational models, and ongoing development of a behavioral health workforce will occur in partnership with others.

Appendix D - User Group Organization

Milwaukee County

Behavioral Health Division Facility Programming
User Group Organization
March 23, 2015

ROLES

User Groups or Department Heads: Responsible for understanding the detailed day-to-day workings of their service or department and on that basis able to offer advice to the architects relative to need. The User Groups will be vetting our program at the level of their department of service (including physical relationships to other departments/services) and will help us to understand the detailed and prescriptive needs of their department that need to finds expression in the facility program.

Steering Committee: This group establishes the key overarching project goals at the level where they impact the hospital as a whole or the hospital's mission and purpose. This is the first group to whom the project will be shared at major milestones and from whom critical reactions will be requested. This group is responsible for setting the standards, purposes, needs, and goals that drive the remainder of the work. This group is also a sounding board for the A/E team with respect to clarifying that which is heard but not completely understood and for reconciling any differences of opinion between and among User Groups or between an individual User Group's requests and a larger policy decision that has been taken.

This Group is also responsible for guiding the Facility Programming process itself and the form of the output. It is only secondarily concerned with the content of the program deferring to the other groups for content. This is the Group that is responsible for keeping the trains running on time and on the right tracks.

Membership

User Groups: The ideal User Group member has detailed content knowledge at the operational level, a critical understanding of the organizations overarching mission and her department's role in achieving that mission, ideas about how to improve service delivery, and sufficient foresight, flexibility and imagination to see the critical future relationships between physical environment and operations. The ideal User Group member rarely exists and so the best User Groups are made up of people who collectively have these characteristics. Simply assigning people based upon the functional job descriptions/roles identified below is not sufficient.   It is understood that for this engagement some user groups may consist solely of a Department Head and perhaps a supervisory staff person to assist.

- Inpatient Services
    - Chief of Inpatient Service/Chief of Psychiatry
    - Director of Nursing or Assistant Director of Nursing
    - Service Line Managers for Each Inpatient Service
    - Patient Advocate
    - Two or Three Front Line RN's
    - One or Two Therapy Aides
    - Two or Three from the On-Unit Clinical Disciplines (SW, Psychology, Medicine)
- Clinical Services/Outpatient Services
    - Chief of Outpatient Services/Chief of Psychiatry
    - Service Line Managers for Each Outpatient Service
    - One or Two Persons from each Clinical Discipline
    - One or Two Persons responsible for Intake, Registration, Case Management or Financial Management
- Dietary
    - Director of Food Services
    - Service Line Managers for One or Two Inpatient Services
    - One or Two Front Line RN's
    - Dietician
    - One or Two Cooks
- Therapy Activity/Adjunctive Therapies
    - Chief of Inpatient Service/Chief of Psychiatry
    - Director of Nursing or Assistant Director of Nursing
    - Service Line Managers for One or Two Inpatient Services
    - Director of rehabilitation Services
    - Three or Four Representatives from Adjunctive Therapies Disciplines/Services
    - Patient Advocate
- Clinical Ancillaries
    - Chief Medical Officer
    - Director of Nursing or Assistant Director of Nursing
    - Dentist
    - Clinic Manager
    - Radiologist
    - Chief Pharmacist
    - Director of Lab Services

- o Director of OT, Vocational and PT Services
- Information Technology and Integration
  - o Director of Medical Records
  - o Director of IT Services
  - o Director of Management Information Services
  - o QA/IR Director
  - o Legal Services Coordinator
- Facilities Management
  - o Chief Operating Officer or Director for Support Services
  - o Director of Facilities/Maintenance
  - o Director of Housekeeping
  - o Director of Transportation
  - o Director of Safety/Security
  - o Director of Materials Management
- Administration
  - o Chief Operating Officer
  - o One representative from each major functional area to be accommodated

Steering Committee: Representation from the senior leadership within mental health services and operations.

Milwaukee County
Milwaukee County Mental Health Center Programming Study
March 23, 2015

Group #		Interview Duration (Hrs)		
		Round 1	**Round 2**	**Confirmation Teleconference**
CLINICAL SERVICES				
1	**Inpatient Services**	4.5	3.0	2.0
1a	Acute Mental Health			
1b	Child and Adolescent Mental Health			
1c	PCS/Observation			
MENTAL HEALTH OUTPATIENT/OUTREACH SERVICES		1.5	2.0	1.5
2	In-Hospital Outpatient Programs			
2	In-Hospital Community Support Programs			
THERAPY/ACTIVITY			1.5	1.0
3	**Inpatient Activity/Adjunctive Therapies, Main Lobby /Patient and Family Services**			
	Rehab Leadership			
	Physical Therapy			
	Occupational Therapy			
	Recreation Therapy/Gym			
	Music Therapy			
	Patient Library, Patient Education, Technology Center			
	Bank/Patient Property			
	Chapel/Spiritual Care			
	Café/ Coffee Shop			
	Canteen/Gift Shop			
	Patient Advocate			
	Peer Support Services			
	Volunteers			
	Lobby Services			
	Transportation/Community Integration			
	Outdoor Functions			
CLINICAL ANCILLARIES				
4	**Pharmacy**		1.5	1.0
4	**Medical Clinic**			
	Medical Clinic			
	ECT/TMS			
	EKG			
	Other?			
INFORMATION TECHNOLOGY & INTEGRATION				
5	**Information Tech & Integration**		1.5	1.0
	Management Info Services			
	Health Records (incl electronic record)			
	Electronic/Data/Systems Integration			
BUILDING SUPPORT				
6	**Facilities Management**		1.5	1.5
	Environmental Services			
	Housekeeping			
	Laundry & Linen Supply			
	Maintenance Shops			
	Employee Lockers/Toilets			
	Transportation (Building/Grounds)			
	Security			
	Mail Room/Duplicating			
	Fire/Safety			
	Telecommunications			
	Materials Management			
	Central Supply/Warehouse/Storage			
FOOD SERVICES				
7	**Food Services**		1.5	1.0
ADMINISTRATION				
8	**Administration**		1.5	1.0
	Hospital Administration			
	Clinical and Nursing Administration (inc GRASP)			
	ORB Consent/Capacity			
	Finance/Cashier			
	Human Resources			
	Other Shared Administrative Support (photocopiers, etc.)			
Steering Committee				
9		2.0	2.0	2.0

Milwaukee County
Milwaukee County Mental Health Center Programming Study
March 23, 2015

PATIENTS AND FAMILIES			
10		TBD	TBD
	8.0	16.0	12.0

Appendix E - Questionnaire Responses and Data

Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire

Adult Inpatient Units

March, 2015

Completed By: Name:	Contact (phone and email)
(LEAD)Alicia Modjeska	
John Schneider	
Pat Schroeder	
Jennifer Bergersen	

Please return this questionnaire by the end of business on Friday, JuMarchne 27, 2015
to Mr. Francis Pitts at pittsf@aplususa.com.

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

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6.   The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7.   Please state when information is not available or estimates are provided as answers to any questions.

8.   If any question does not relate to your department, please indicate "Not Applicable".

9.   It is requested that the nominated 'lead' assemble the collected response on March 27, 2015.

10.   Please forward your completed consolidated questionnaire to Francis Pitts by April 3, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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What are your three or four most important goals for the project? What are the measurable objectives that are tied to each goal? How will we know if we have met the goal? What are the significant obstacles the might interfere with meeting the identified goal?

> Francis Pitts 4/7/15 11:55 AM
> **Comment [1]:**

1.1.   How should beds be distributed across units/sub-units?

> Francis Pitts 4/9/15 2:34 PM
> **Comment [2]:**

Unit Name or Cohort	Unit Beds	Sub-Unit Cohort	Sub-unit Beds
Acute Adult	24	A	8
		B	8
		C	8

1.2. What percentage of the beds in each unit should be private? Semi-private?

All private rooms

1.3. What are the types of medical complications that will need to be treated on the unit? What are the space and equipment needs to accommodate these conditions?

Minor wounds and injuries, chronic -> diabetes, respiratory conditions, and congestive heart failure

Clean utility areas for minor equipment, supply room

2.   Program/Service Description – this questionnaires covers the inpatient residential programs for:

Intensive acute treatment units

2.1. Please provide information that summarizes the current mission and scope of service/operations for your program/service

Voluntary as well as detained populations

> Francis Pitts 4/10/15 10:58 AM
> **Comment [3]:** Safe compassionate care, recovery oriented, for a successful return to the community

2.2. How and by whom will the service be licensed and accredited? What is the relevant regulation for facility planning and design?

WI DHS 124, CMS conditions of participation, COP, and JCAHO standards

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2.3. Please provide your thoughts on the changes over the next five to ten years that will occur to the nature of the program and its services in moving to a new facility (this could be an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, etc.)

Continue to focus on -> High acute patients with very challenging behaviors

Med psych beds: mobile oxygen concentrators, chronic conditions and frailty , two rooms on each unit big enough for hospital beds

Chapter 55

Co-occurring AODA, no detox area; would take patients with minor withdrawal symptoms

Francis Pitts 4/7/15 12:18 PM
Comment [4]: How many? Clinical competency?

Francis Pitts 4/10/15 11:02 AM
Comment [5]: Protective Services System and involuntary comnfinement…how does this imp[acvty? What changes are expected? Only a few patientsm have a Guardian. It is very unusual currently

Francis Pitts 4/7/15 12:20 PM
Comment [6]: Alchohol and Other Drug Abuse

Francis Pitts 4/10/15 11:03 AM
Comment [7]: What are percentages?

2.1. Where are your patients arriving from? How are they admitted? Admitted (e.g., booked and processed prior to arriving, unscheduled arrival?; Admission interview & exam ideally will happen centrally or on-unit, etc.)

100% of admissions are through the PCS or Observation

Walk ins' under voluntary conditions.

Through law enforcement process

If there is any question about medical stability these patients are first sent to and screened by acute care hospitals

2.2. To where are they discharged? How?

Numerous places including group homes, supportive homes, CBRF, home

2.3. What is your current alos (average length of stay)? Are there significant outliers that lead to a different mlos (median length of stay)?

8-9 days is our average los

2.4. Who are your patients? Are they characterized by important cultural or socio-economic characteristics that should be considered in the design process?

SEE ATTACHED REPORT

3. Please respond to the following Patient Profiles for **both Current and Projected** populations. The purpose of this information is to assist the planners in understanding any specific facilities requirements that would in turn assist you in caring for these individuals.

3.1. the approximate percent split of the inpatient population that is/will be ambulatory and non-ambulatory

Current: 98% are ambulatory

Future: same

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3.2. What percentage of patient bedrooms should be HC accessible?

2-5%

3.3. the percentage of the patients with physical transfer requirements and the type of transfer

Current: 1-2%

Future: same

the percentage of the patients with incontinence problems and the nature of these

Current: 5%

Future: same

SEE ATTACHED REPORT FOR QUESTIONS IN GRID

3.4. Please provide the number or percentage of patients with the following diagnoses for your current and future patient populations:

% of patients with a primary diagnosis of:	Current	Future
Cognitive Impairment	xx	xx
Obsessive Compulsive Disorder	xx	xx
Neurological	xx	xx
Dual Diagnosis MH/MR	xx	xx
Dual Diagnosis (MH/Addictions)	xx	xx
Mood & Anxiety Disorders	xx	xx
Schizophrenia	xx	xx
Other mental illness related to aging	xx	xx
Significant co-existing medical condition	xx	xx
Others –		

3.5. Behavioral Characteristics: please identify the percentage of your patient population with a significant presentation of the following characteristics currently and in the future:

% of patients with the following behavioral characteristics:	Current	Future
Aggression towards others	xx	xx
Elopement risk	xx	xx
Sexual inappropriate behaviors	xx	xx
Pica (Ingestion of non-food products)	xx	xx
Property destruction	xx	xx
Hydrophilia	xx	xx

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3.6. Patient age: please identify:

	Current	Future
Male/Female split (approximate %-age)	xx	xx
Age Range	xx	xx
Average Age	xx	xx

xxx

4. Please provide a summary of key clinical activity on-unit by the professions listed below where specific services are delivered that will influence the facility/environment considerations. The comments you provide may relate to current services that will remain valid and necessary in the future environment or services that are not/cannot currently be provided that will be necessary in the future. Please consider the response in the context of the future patient profile.

Psychology – Testing and assessment, individual therapy

General Medicine – H&P, disease specific consults, minor procedures such as suture removal, wart removal wound care, staple removal.

Psychiatry – medication therapy, assessment, education. No ECT or hydrotherapy

Social Work - financial counseling, community services, family therapy, referrals

Occupational Therapy – assessment, functional OT, community assessment for level of care, adaptive devices.

Recreational Therapy – music and structure activities

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5. List the main program elements (spaces or functions) of each area.   This includes key features of your program. Please focus also on elements that relate to shortcomings of your area in relation to your concept of ideal patient care services and patient and staff environments.

    Groups, individual treatment, education

    Need seclusion room, restraint room, conference room, break room for staff, office space for physician and manager, Sensory room, dining area, nurses station, medication room, consultation space, pat belonging storage, clean and dirty utility, space for a washer and dryer, treatment room, multiple group rooms.

> **Francis Pitts 4/10/15 11:11 AM**
> **Comment [10]:** Exam Room

> **Francis Pitts 4/10/15 11:11 AM**
> **Comment [11]:** Group Therapy

5.1. What does your ICRA suggest with respect to the number, nature and location of isolation rooms?

       We currently use isolation carts, would like to have 2 negative pressure rooms someplace, but not in the ITU.

> **Francis Pitts 4/10/15 11:11 AM**
> **Comment [12]:** Supply cart for an individual patient

> **Francis Pitts 4/10/15 11:12 AM**
> **Comment [13]:** Inpatient Treatment Unit? If not there, then where? One in Obaservation and one in PCS

5.2. What is your contact hours targets per day or per week for active treatment (clinical/therapy functions) for each patient group?

       8 hrs.

> **Francis Pitts 4/10/15 11:14 AM**
> **Comment [14]:** Look at # of treatment hours per patient by discipline

5.3. Where do you want to provide the patient laundry (on-unit or off-unit)? How many washers and dryers will be needed? What else is needed in the Laundry Room? (Please note that regulations require that Laundry Rooms be on-unit or readily accessible to units and that one be provided on each nursing floor.)

       Yes, one washer and dryer per unit.

5.4. Where are patient belongings stored or where should they be stored?

       Belongings stored in central area and managed by security.

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5.5. Does the nursing/direct care staff have access to the housekeeping/janitors closets for cleaning supplies and for cleaning up the occasional spill?

Yes.

5.6. How are snacks and beverages delivered, stored, and distributed?

A PAR level of snacks in the kitchen area or in unit pantry. Need patient refrigerator

> **Francis Pitts 4/7/15 12:22 PM**
> **Comment [15]:** Normal?

5.7. Where should the staff break room be located?

In unit. Should also provide for one general break room for all staff outside the units.

5.8. Should staff lockers be provided? If so, where? How many? What size?

Yes, full size to accommodate large coats and boots during winter months. Would like a separate area for female and male lockers size based on % of female vs male workers.

> **Francis Pitts 4/10/15 11:18 AM**
> **Comment [16]:** On unit? No, off unit and adjacent. Lockers don't belong to individual staff.

5.9. Do visitors, staff and patients require separate toilet facilities in common areas? (This would be in addition to the toilet rooms at patient bedrooms?)

Yes, designated for staff, visitors and patients

5.10. Based on the format of the clinical treatment program, how many Consultation Rooms are needed on the unit? Adjacent to the unit? (Regulations require a minimum of one per 12 beds readily and on or readily accessible to each inpatient unit with at least one of these being located on each nursing floor.)

Yes, follow regs and placed in units.

5.11. Based on the format of the clinical treatment program, how many Group Rooms are needed on the unit? Adjacent to the unit? (Regulations require a minimum of one per unit with at least one of these being located on each nursing floor.)

2-3 per unit, and also need a family consult room.

> **Francis Pitts 4/10/15 11:20 AM**
> **Comment [17]:** In addition to other rooms? No…what we are doing covers this need.

5.12. How many Soiled Utility/Soiled Linen Rooms are needed? Can they be combined?

1 per unit and yes, they can be combined.

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5.13. How many Clean Utility/Clean Linen Rooms are needed? Can they be combined?

Yes, and can be combined

5.14. Are Comfort Rooms, Snoezelin Rooms or Sensory Modulation Rooms needed? If so how many and where should they be located?

Sensory modulation room one in each unit.

5.15. What style of nursing station is desired?

We know what we don't want, but do not know what we want. We would like to see options.

5.16. How many seclusion rooms will be needed? Do they need to be padded?

1 restraint and 1 padded seclusion in every unit.

5.17. What admissions functions will take place on the unit?

Medical H&P, treatment plan, belongings tabulation, medication reconciliation, nursing assessment and admission process, weight, height, pain and fall risk assessment.

If this question is about registration functions- all registration functions will be done centrally, physical location close to PCS

Francis Pitts 4/7/15 12:23 PM
Comment [18]: History and Physical

5.18. How many exam rooms are needed?

1 exam room per unit or possibly shared between two units if they are close to one another.

6. Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

Internal operations:

xxx

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Please specifically address the following issues:

Work Flow Functional Characteristics/ Shortcomings:	Comments
Medication Administration	Need larger medication rooms to accommodate information technology e.g. – Pyxis machines, refrigeration of meds, computers, bar coding etc.
Meal Service /Dining Style (e.g. trays, bulk, family style?)	We currently have food delivered to the facility and is brought to the unit. It works well. Will need transportation carts and keeping food at the right temperature. Also need plates/silverware storage. Refrigeration, warming units/microwave, storage for snacks.
Food Preparation (on-unit, off-unit?)	Food preparation all done off units, need area to store carts Area needed to either wash dishes or workflow changed to take dirty dishes off campus.
Level of Supervision required on unit	All nursing managers need offices on units
Level of Supervision off unit	Need secure public areas, Director / program administrator individuals need to be in building but not on unit.
Equipment Room	PLEASE- never have enough storage space for wheelchairs, scales, BP machines, equipment, scales, Hoyer lifts, hampers dirty and clean/ washer and dryer, janitor closet for cleaning supplies. Eye wash stations/ would like to see one tub room in the facility.
Crash Cart	Yes, but not in every unit/ need isolation cart storage

7. Please comment on the following Program Policy Considerations:

Program Policy Consideration:	Comment:
Off/On Patient Care Unit (PCU) living area Recreation/Leisure time Activities	Want to do as many activities and cares on the unit as possible, including PT, OT.
Patient space access/restrictions related to:	
• On-unit Kitchen	See above, storage needed, refrigeration/microwave.
• Dining Area	Yes, small tables, would like some space to be able to separate certain individuals from the rest of the group. Safe furniture/not breakable.
• Exit doors	Limit the number of entrances and egress to eliminate elopement potential, vestibules would be good. Need one entrance and one exit.
• Bathrooms	One for each room/ all equipment in bathrooms need to be "suicide proof" bathroom should include sink, shower, and toilet. Need piano hinge, Also need bariatric bathrooms. Not all but ¼ off all bathrooms

Francis Pitts 4/10/15 11:24 AM
Comment [19]: Only one combined entrance/exit

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	should have bariatric facilities.
• Bedrooms	One per patient, appropriate storage/ safe beds – platform. Need proper storage personal belongings, clothing, towels etc. self-contained ceilings
• Leisure space	Access to fresh air in a well contained area. A lounge area that is not necessarily the dining room. Space for physical activity/yoga/exercise bikes etc. storage for this type of equipment. Music piped into the unit. Sometimes musicians bring in equipment. TV's dining area, group rooms, also include area for X-box. No TV's in individual rooms.
Time out/seclusion room policy	Need for seclusion rooms, these rooms are used for short periods of time to de-escalate. Would like to have this room include padded walls if possible.
Clinical treatment/office space on/off unit	Want a room for physicians, social workers, OT's and MT's or can have one large combined area where these individuals could document. Also could use individual therapy rooms 2 "swing type" rooms. Need to be able to see into these rooms.
Day Services on/off PCU	Day treatment area where we could send patients- would want to discuss this option more to explore possibilities. We also need a court room with several waiting areas as we need to separate patients from families at times, also need separate confidential areas for attorney and patient, areas for policy officers to wait to transport patients back to other hospitals.
Visual/Auditory observation requirements	Group rooms need to be glassed in. Need to have good vision from the nurse's station. All areas should be within eye sight
School age Education, On/Off PCU unit	Not for adults, just children
Requirements for Community Living Skills Training On/Off unit	Supportive apartments- would like to have one available so the OT could do assessment, would like this area to be on the unit so patients would not need to be transferred or moved to another site.
• Mock Apartment	Yes, shared between two units for training purposes
• Kitchen	Yes, see above
• Dish washing	Yes, see above
• Dining	Yes, see above
• Home-like bathroom	Yes, see above
• Other?	
Vocational Training	
• In-House	No hands on vocational training, referrals to sheltered workshop. Would like to have these providers on site.
• In-Community	yes
Family Visitation (on-unit/off-unit; restrictions, need for supervision, etc.)	Yes, on and off unit. With or without supervision
Special (Assisted) Bathing Facilities	One tub room
Outdoor Space	Yes, for relaxation and recreational activities
Smoking	No

Francis Pitts 4/10/15 11:26 AM
Comment [20]: Two consult rooms shared between and among clinicians with vision panels

Francis Pitts 4/7/15 12:05 PM
Comment [21]:

Francis Pitts 4/10/15 11:28 AM
Comment [22]: Do they really mean Group Rooms? Yes!

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8. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

We cannot think of anything at this time.

9. Please note any differing opinions that still exist at the conclusion of your discussions:

Our system continues to evolve and our needs are based on what we know today. It may be different in two months. For example, med pysch, gero-psych, chapter 55 etc. Focused on more acute, developmental disability needs, AODA.

> Francis Pitts 4/9/15 3:28 PM
> **Comment [23]:** Discuss

10. Please describe any other anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Technology is being enhanced and would like to maximize the use of technology wherever possible. May need more mobile equipment/technology. The use of mobile courtroom or tele psychiatry. Expanding the use of case management/care coordination among the entire healthcare system, using technological supports wherever possible.

10.1. Please note any differing opinions that still exist at the conclusion of your discussions:

We are well aligned in our thinking

11. Please list the titles of current staff and number of FTE's and Bodies in each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others – this will enable us to appropriately size the offices for the most common situations.

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Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – i.e. hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

11.1.   What are your direct care staffing ratios/patterns?

census of 12-24 patients per unit/ 2 pods per unit ** this is for a general unit

Day Shift: 1RN : 6 patients, 1 CNA: 6 + CNS for 1:1?? 1 psychiatrist : 12 patients

PM Shift: same as above + house psychiatrist 24/7 on site

NOC Shift: 1RN : 12 patients, 2 CNA's per 12 patients + house psychiatrist

The intensive treatment unit: pods of 6 patients for a total of 24

1RN and 1NA per pod for 6

PCS staffing see PCS questionnaire

CAIS – see specific questionnaire

<mark>Please describe post-positions per shift. As an example, please change the following accordingly:</mark>
3 RN and 2 CAN/MHT's on 8 AM-8PM, plus unit sec'y,
3 RN and 2 CAN/MHT's on 8 PM-8AM

Report attached.

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
xxx	x	X	X	X	X	x
MH Tech's/ Certified Nurse Assistant's	x	X	X	X	X	X
SW	x	X	X	X	X	X
OT	x	X	X	X	X	X
Residents	X	X	X	X	X	X
Psychiatrist	X	X	X	X	X	X
Clinical Nurse Specialist	X	X	X	X	X	X
Nurse Manger	X	X	X	X	X	X
Unit Secretary	X	X	X	X	X	X

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Medical Students	X	X	X	X	X	X
Case Mangers	X	X	X	X	X	X
Psychology (see note in item 4) which is correct?	X	X	X	X	X	X
Nurse Practitioner (see note in item 4) which is correct?	X	X	X	X	X	X

11.2.   What specific changes should we anticipate with respect to future staffing?

We anticipate that ratios will remain the same for all clinicians except psychologist.

11.3.   Where should staff offices be located?

Some offices should be located in the care units and some can be located off the unit with correct adjacencies. We are looking for generic staff/patient interaction rooms which could be scheduled and shared among clinical providers.

12. Adjacency Requirements

Describe *ideal critical internal adjacency relationships* within your area(s), regardless of whether these are currently achieved or not possible. These relationships may be a result of patient flow, material flows, or staff movements or supervision needs

Between (function/area)	And (function/area)	Reason
Nursing units		
Nursing station	Med room/clean and dirty utility / charting area/ treatment room Storage of IT/cameras/ patient belongings which cannot be kept in room but patient uses every day. Staff rest room/time clock/main control panels	Supplies which need to be segregated and secured
	Visitor room/seclusion room/quiet room all within eye sight of the nursing station/ isolation room Isolation room for infections/ should have a separate storage area for PPE	

> Francis Pitts 4/7/15 12:09 PM
> **Comment [24]:** Personal Protection Equipment?

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Nursing unit	Physician offices	Office in unit- ideal
	Social service office	Same as above
	OT/PT/MTPT	No need for office in unit / OT & MT office however should be on unit
	Lawyers	Can use a generic swing office
	Case managers	Can use a generic swing office
	dietitians	No office needed on unit but close by
	Clergy/spiritual services	Can use generic swing office
	AODA / intake screening outside vendors	Can use generic swing office
	Peer specialists	Same as above
	Nursing manager	On unit
	Security??	Needs some type of general space for all security as a home base, no need to be close to units

Francis Pitts 4/10/15 11:35 AM
Comment [25]: Music Therapist

Francis Pitts 4/10/15 11:29 AM
Comment [26]: Music Therapist

12.1.   Please note any differing opinions that still exist at the conclusion of your discussions:

NA

13. Describe critical ideal future external adjacency relationships that each area has with other departments in the facility. These relationships may be a result of patient flow, materials flow, or staff movements

    Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR   REASON INDICATOR
1 - Directly next to   A - Patient movement
2 - Same floor   B - Staff movement
3 - Doesn't matter   C - Materials movement

Department	Closeness	Reason	Contacts/Day
Nursing/Patient unit; the patient unit needs to be the center of the universe or main customer	PT		
dietary	Same floor	Patient movement	
security	Same floor		
Courtroom/legal offices	Same floor		
Case managers	Same floor		
Cafeteria	Does not matter		
HR	Does not matter		
Medical records	Does not matter		
administration	On site- does not matter		
IT	Does not matter		
Pharmacy	Same floor: Convenient		

Francis Pitts 4/10/15 11:36 AM
Comment [27]: Near...not same floor

Francis Pitts 4/7/15 12:12 PM
Comment [28]: Discuss all same floor comments

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Chapel	Same floor		
Nursing administration	Does not matter		
Social services	On unit		
Physicians	On unit		
Rehabilitation – PT and speech	Does not matter		
Medical records	Does not matter		
UR & QA	Does not matter		
EAP	Does not matter		
Education	Does not matter		
Business office	Does not matter		
Communications/Marketing	Does not matter		
Central Stores	Does not matter		
Court rooms	Same floor		
On call sweet	Does not matter		
Research	Does not matter		
Lobby services	Same floor		
Pharmacy	Same floor: Convenient		
Registration	Same floor: Convenient		
Dietitians	Does not matter		
Housekeeping	On unit/ general area located elsewhere		
Safety/security	Does not matter		
Communications	Does not matter		
Maintenance	Does not matter		
Infection control	Does not matter		
Transportation /van	Same floor/bay area for vans		
Grounds keeping	Does not matter		
registration	Does not matter		
PCS	Same floor: Convenient		

Please note any differing opinions that still exist at the conclusion of your discussions:

14. Please list materials, space, personnel or other resources that you share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
Tub room		
We don't share anything else we can think of.		

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15. What is the appropriate setting for types of patient care with respect to the in-patient unit, areas directly adjacent to the inpatient unit and a central program mall?

   We could share nursing stations and everything attached to the station, for example clean and dirty utility, same med room, shared treatment rooms. Shared visitor space, or shared staff lounge/shared restrooms/locker rooms.

16. What is the appropriate clinician mix, direct care staff involvement, patient density, spaces, and modalities in on-unit or neighborhood spaces

   Refer to FTE ratio/grid

17. What are the major risks that need to be managed for each patient cohort? What are the physical implications of same? We have an ITU which requires more space, possibly additional quiet room/restraint area./activity room

18. Please comment on the need (if appropriate) for the following Assistive Technology – Adaptive Equipment. Do you anticipate this to change, and if so, please briefly describe the nature of the change?

Assistive Technology-Adaptive Equipment	Need (e.g. high/moderate/low/no need):
Physical Transfer Equipment (Hoyer lifts etc)	Low - moderate, lifts/walkers
Respiration Equipment	low
Oxygen	low
Tube feeding equipment	low
Special needs ambulation/transport (Electronic Scooters/mechanical tricycles etc.)	low
Communication Equipment	low
Specialized Bathing Equipment (Hoyer lifts etc.)	low
Personal Duress Alarm System	high
Other (please specify)	NA

19. What are or will be the most critical decisions that will be made with respect to this project?

   Making sure we have enough room for storage. Using IT to its fullest potential re: safety/workflow. Configuring the units to be patient centered, and does not feel like a jail, but is very safe, secure and therapeutic.

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20. What outcomes are most important for your inpatient unit's mission? What environmental variables do we suspect or know are most critical for achieving those outcomes?

Quiet space, lots of open areas to heal and recover with appropriate supervision, areas to exercise, and an environment develop in a way it feels like home/not a hospital yet is still safe and therapeutic.

21. What applicable research or evidence do you have or know about which might impact how the project is developed or designed?

PLANE TREE model, Trauma informed care models of treatment, treatment mall model.

Francis Pitts 4/7/15 12:13 PM
Comment [29]:

22. This there any other information or data that you feel the planning team should be aware of that has not been requested by this questionnaire?

TBD at stakeholder meetings.

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Child and Adolescent Inpatient Units

for the

Milwaukee Board of Health

Questionnaire

Child and Adolescent Units

March 10, 2014

Completed By: Name	Contact (phone and email)
(LEAD)	
Jennifer Bergersen	
Alicia Modjeska	

Please return this questionnaire by the end of business on Friday, March 27, 2015
to Mr. Francis Pitts at pittsf@aplususa.com.

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for children and adolescents with serious and persistent mental illness, to replace the current programs and facilities operated by the Milwaukee Board of Health.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th, involving representatives from the County. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

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6.   The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7.   Please state when information is not available or estimates are provided as answers to any questions.

8.   If any question does not relate to your department, please indicate "Not Applicable".

9.   It is requested that the nominated 'lead' assemble the collected response by the time of the workshop.

10. Please forward your completed consolidated questionnaire to Francis Pitts. Forwarding it as an electronic document attached to the following email address is preferred pittsf@aplususa.com

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What are your three or four most important goals for the project? What are the measurable objectives that are tied to each goal? How will we know if we have met the goal? What are the significant obstacles the might interfere with meeting the identified goal?

1.1. How should beds be distributed across units/sub-units?

Unit Name or Cohort	Unit Beds	Sub-Unit Cohort	Sub-unit Beds
C&Y	18	A	6
		B	6
		C	6

1.2. What percentage of the beds in each unit should be private? Semi-private?

Same size as adults

1.3. What are the types of medical complications that will need to be treated on the unit? What are the space and equipment needs to accommodate these conditions?

2. Program/Service Description – this questionnaires covers the inpatient residential programs for:

Child and adolescent unit: acute stableizatio for children, addressing phsychopharmacoloyt and referring children to resources in the community. There is a school located in the hospital to provide the needed education. The LOS is 2-3 days. Family and sibling encouraged to interact and are supported through community aftercare resources such as Wrap-around. These children are covered by insurance. A lot of behavioral modification, anger management, self esteem, individual/independence skill training, mood disorders, depression

2.1. Please provide information that summarizes the current mission and scope of service/operations for your program/service

same

2.2. How and by whom will the service be licensed and accredited? What is the relevant regulation for facility planning and design?

same

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2.3. Please provide your thoughts on the changes over the next five to ten years that will occur to the nature of the program and its services in moving to a new facility (this could be an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, etc.)

We need to truly develop this program as a nitch to care for those children with the most challenges.

2.1. Where are your patients arriving from? How are they admitted? admitted (e.g., booked and processed prior to arriving, unscheduled arrival?; Admission interview & exam ideally will happen centrally or on-unit, etc.)

Refered from schools, family, group homes, child protective agencies, child welfare, correctional.

2.2. To where are they discharged? How?

Same

2.3. What is your current alos (average length of stay)? Are there significant outliers that lead to a different mlos (median length of stay)?

Short 2-3 days/ very intensive acute care, 3.5 days ALOS

2.4. Who are your patients? Are they characterized by important cultural or socio-economic characteristics that should be considered in the design process?

Refer to data attached.

3. Please respond to the following Patient Profiles for **both Current and Projected** populations. The purpose of this information is to assist the planners in understanding any specific facilities requirements that would in turn assist you in caring for these individuals.

3.1. the approximate percent split of the inpatient population that is/will be ambulatory and non-ambulatory

Current: ambulatory

Future: ambulatory

3.2. What percentage of patient bedrooms should be HC accessible?

10%

Francis Pitts 4/9/15 3:40 PM
Comment [2]:

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3.3. the percentage of the patients with physical transfer requirements and the type of transfer

Current: low to none

Future: low to none

the percentage of the patients with incontinence problems and the nature of these

Current: low to none

Future: low to none

3.4. Please provide the number or percentage of patients with the following diagnoses for your current and future patient populations: SEE ATTACHED CHART

% of patients with a primary diagnosis of:	Current	Future
Cognitive Impairment	xx	xx
Obsessive Compulsive Disorder	xx	xx
Neurological	xx	xx
Dual Diagnosis MH/MR	xx	xx
Dual Diagnosis (MH/Addictions)	xx	xx
Mood & Anxiety Disorders	xx	xx
Schizophrenia	xx	xx
Other mental illness related to aging	xx	xx
Significant co-existing medical condition	xx	xx
Others –		

3.5. Behavioral Characteristics: please identify the percentage of your patient population with a significant presentation of the following characteristics currently and in the future:

% of patients with the following behavioral characteristics:	Current	Future
Aggression towards others	xx	xx
Elopement risk	xx	xx
Sexual inappropriate behaviors	xx	xx
Pica (Ingestion of non-food products)	xx	xx
Property destruction	xx	xx
Hydrophilia	xx	xx

SEE ATTACHED CHARTS

3.6. Patient age: please identify:

	Current	Future

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Male/Female split (approximate %-age)	xx	xx
Age Range	xx	xx
Average Age	xx	xx

SEE ATTACHED CHART

4. Please provide a summary of key clinical activity on-unit by the professions listed below where specific services are delivered that will influence the facility/environment considerations. The comments you provide may relate to current services that will remain valid and necessary in the future environment or services that are not/cannot currently be provided that will be necessary in the future. Please consider the response in the context of the future patient profile.

Psychology – xx

General Medicine – xx

Psychiatry – xx

Social Work - xx

Occupational Therapy – xx

Recreational Therapy – xx

SAME AS THE ADULT UNIT, WITH THE EXCEPTION OF THE SCHOOL PROGRAM

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5. List the main program elements (spaces or functions) of each area.   This includes key features of your program. Please focus also on elements that relate to shortcomings of your area in relation to your concept of ideal patient care services and patient and staff environments.

    SAME ISSUES; SCHOOL SETTING ADJECENT.

    5.1.   What does your ICRA suggest with respect to the number, nature and location of isolation rooms?

    NONE

    5.2.   What is your contact hours targets per day or per week for active treatment (clinical/therapy functions) for each patient group?

    See attached documents

    5.3.   Where do you want to provide the patient laundry (on-unit or off-unit)? How many washers and dryers will be needed? What else is needed in the Laundry Room? (Please note that regulations require that Laundry Rooms be on-unit or readily accessible to units and that one be provided on each nursing floor.)

    Same

    5.4.   Where are patient belongings stored or where should they be stored?

    same

    5.5.   Does the nursing/direct care staff have access to the housekeeping/janitors closets for cleaning supplies and for cleaning up the occasional spill?

    same

    5.6.   How are snacks and beverages delivered, stored, and distributed?

    same

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5.7. Where should the staff break room be located?

Same as adult

5.8. Should staff lockers be provided? If so, where? How many? What size?

Same as adults

5.9. Do visitors, staff and patients require separate toilet facilities in common areas? (This would be in addition to the toilet rooms at patient bedrooms?)

See adult survey

5.10. Based on the format of the clinical treatment program, how many Consultation Rooms are needed on the unit? Adjacent to the unit? (Regulations require a minimum of one per 12 beds readily and on or readily accessible to each inpatient unit with at least one of these being located on each nursing floor.)

Same; the difference in this unit is families and sibblings visit the children resulting in the need for larger consultation and visiation area.

5.11. Based on the format of the clinical treatment program, how many Group Rooms are needed on the unit? Adjacent to the unit? (Regulations require a minimum of one per unit with at least one of these being located on each nursing floor.)

same

5.12. How many Soiled Utility/Soiled Linen Rooms are needed? Can they be combined?

same

5.13. How many Clean Utility/Clean Linen Rooms are needed? Can they be combined?

same

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5.14. Are Comfort Rooms, Snoezelin Rooms or Sensory Modulation Rooms needed? If so how many and where should they be located?

same

5.15. What style of nursing station is desired?

TBD- need to evaluate options

5.16. How many seclusion rooms will be needed? Do they need to be padded?

same

5.17. What admissions functions will take place on the unit?

same

5.18. How many exam rooms are needed?

same

6. Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

Internal operations:

Same as adult survey

Please specifically address the following issues:

Work Flow Functional Characteristics/ Shortcomings:	Comments
Medication Administration	xxx
Meal Service /Dining Style (e.g. trays, bulk, family style?)	xxx
Food Preparation (on-unit, off-unit?)	xxx
Level of Supervision required on unit	xxx
Level of Supervision off unit	xxx
Equipment Room	xxx

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Crash Cart	xxx

7. Please comment on the following Program Policy Considerations:

Program Policy Consideration:	Comment:
Off/On Patient Care Unit (PCU) living area Recreation/Leisure time Activities	xxx
Patient space access/restrictions related to:	
• On-unit Kitchen	xxx
• Dining Area	xxx
• Exit doors	xxx
• Bathrooms	xxx
• Bedrooms	xxx
• Leisure space	xxx
Time out/seclusion room policy	xxx
Clinical treatment/office space on/off unit	xxx
Day Services on/off PCU	xxx
Visual/Auditory observation requirements	xxx
School age Education, On/Off PCU unit	
Requirements for Community Living Skills Training On/Off unit	xxx
• Mock Apartment	xxx
• Kitchen	xxx
• Dish washing	xxx
• Dining	xxx
• Home-like bathroom	xxx
• Other?	xxx
Vocational Training	There is some vocational training in the school
• In-House	xxx
• In-Community	xxx
Family Visitation (on-unit/off-unit; restrictions, need for supervision, etc.)	xxx
Special (Assisted) Bathing Facilities	xxx
Outdoor Space	xxx
Smoking	NONE

8. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

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9. Please note any differing opinions that still exist at the conclusion of your discussions:

---

10. Please describe any other anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

If there was a method to separate the rooms from smaller children from adolescence. Would separate males from females.

10.1. Please note any differing opinions that still exist at the conclusion of your discussions:

---

11. Please list the titles of current staff and number of FTE's and Bodies in each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – i.e. hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

11.1. What are your direct care staffing ratios/patterns? SEE ATTACHED REPORT

Please describe post-positions per shift. As an example, please change the following accordingly:
3 RN and 2 CAN/MHT's on 8 AM-8PM, plus unit sec'y,
3 RN and 2 CAN/MHT's on 8 PM-8AM

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
xxx	x	X	X	X	X	x
MH Tech's/ Certified Nurse Assistant's	x	X	X	X	X	X
SW	x	X	X	X	X	X
OT	x	X	X	X	X	X
Residents	X	X	X	X	X	X
Psychiatrist	X	X	X	X	X	X
Clinical Nurse Specialist	X	X	X	X	X	X
Nurse Manger	X	X	X	X	X	X
Unit Secretary	X	X	X	X	X	X
Medical Students	X	X	X	X	X	X
Case Mangers	X	X	X	X	X	X
Psychology (see note in item 4) which is correct?	X	X	X	X	X	X
Nurse Practitioner (see note in item 4) which is correct?	X	X	X	X	X	X

11.2.   What specific changes should we anticipate with respect to future staffing?

Will continue to specialize in the most serious emotional and behavioral conditions

11.3.   Where should staff offices be located?

same

___

12. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s), regardless of whether these are currently achieved or not possible. These relationships may be a result of patient flow, material flows, or staff movements or supervision needs

Between (function/area)	And (function/area)	Reason

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12.1. Please note any differing opinions that still exist at the conclusion of your discussions:

13. Describe critical ideal future external adjacency relationships that each area has with other departments in the facility. These relationships may be a result of patient flow, materials flow, or staff movements

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR	REASON INDICATOR
1 - Directly next to	A - Patient movement
2 - Same floor	B - Staff movement
3 - Doesn't matter	C - Materials movement

Department	Closeness	Reason	Contacts/Day
same			

Please note any differing opinions that still exist at the conclusion of your discussions:

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14. Please list materials, space, personnel or other resources that you share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

15. What is the appropriate setting for types of patient care with respect to the in-patient unit, areas directly adjacent to the inpatient unit and a central program mall?

16. What is the appropriate clinician mix, direct care staff involvement, patient density, spaces, and modalities in on-unit or neighborhood spaces

17. What are the major risks that need to be managed for each patient cohort? What are the physical implications of same?

18. Please comment on the need (if appropriate) for the following Assistive Technology – Adaptive Equipment. Do you anticipate this to change, and if so, please briefly describe the nature of the change?

Assistive Technology-Adaptive Equipment	Need (e.g. high/moderate/low/no need):
Physical Transfer Equipment (Hoyer lifts etc)	no
Respiration Equipment	xxx
Oxygen	xxx
Tube feeding equipment	xxx
Special needs ambulation/transport (Electronic Scooters/mechanical tricycles etc.)	xxx
Communication Equipment	xxx
Specialized Bathing Equipment (Hoyer lifts etc.)	xxx
Personal Duress Alarm System	xxx
Other (please specify)	Children with seizures or those with autism, a few developmental disabilities

19. What are or will be the most critical decisions that will be made with respect to this project?

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20. What outcomes are most important for your inpatient unit's mission? What environmental variables do we suspect or know are most critical for achieving those outcomes

21. What applicable research or evidence do you have or know about which might impact how the project is developed or designed

22. This there any other information or data that you feel the planning team should be aware of that has not been requested by this questionnaire?

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire

Psychiatric Crisis Services (PCS)

March, 2015

Completed By: Name: Contact (phone and email)

(LEAD)	
Jennifer and Alicia	

Please return this questionnaire by the end of business on Friday, JuMarchne 27, 2015
to Mr. Francis Pitts at pittsf@aplususa.com.

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

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6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on March 27, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 3, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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What are your three or four most important goals for the project? What are the measurable objectives that are tied to each goal? How will we know if we have met the goal? What are the significant obstacles the might interfere with meeting the identified goal?

1.1.   How should beds/recliners be distributed across units/sub-units of the PCS?

Unit Name or Cohort	Unit Beds	Sub-Unit Cohort	Sub-unit Beds
Observation Beds	18	A	6
		B	12
		C	6
PCS	20	Adult	20 Recliners
	6	C&A	6 Couches and Chairs

A spoke model works.

Staffing is at 1:1 within kids

1.2.   What percentage of the beds in each unit should be private? Semi-private?

All privates

1.3.   What are important volume drivers in terms of time of day, day of week or time of year? Please describe/quantify peak volumes and normal volumes.

None, studies afternoon are high census no other trends identified.

> **Francis Pitts 4/10/15 2:35 PM**
> **Comment [1]:** 25-26 is maximum surge absorbed by the space. Probably all that staff could support as well. The last time they went on full divergence in 2008. Divergence is to keep people in safe parallel settings.

1.4.   Discuss circulation from PCS to IPU's on admissions

No issue, would be ideal if PCS was next to IPU and Observation

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1.5.   Where and when should the child and adolescent patients and families be separated
        from adult patients and families?

        They should be separated all the time

1.6.   Discuss wait times for inpatient beds and impact on hold times in the PCS.

There is not too much lag time between PCS and IPU. The typical wait time is 1 hr. of less

1.7.   Will there be a fast-track service within the PCS? If so, describe the fast-track function?
        What % of the volume uses fast-track?

        No this service is not provided, there is a brief assessment who is seen at the door,
        there is no need and are sent back out

1.8.   What % of the volume is admitted?

        10-11%

        10700 PCS-> 1100 to ITU. To observation about 11%.

1.9.   Is there a secondary triage point within the PCS?

        No, initial at the door

1.10.   What are the types of medical complications that will need to be treated within the
        PCS? What are the space and equipment needs to accommodate these conditions?

        Provide first aid for cuts/bruises, anything more major is sent out for medical
        clearance.

2. Program/Service Description – this questionnaires covers the inpatient residential programs
    for:

        xxx

    2.1. Please provide information that summarizes the current mission and scope of
         service/operations for your program/service

        Same as hospital

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2.2. How and by whom will the service be licensed and accredited? What is the relevant regulation for facility planning and design?

same

> **Francis Pitts 4/10/15 2:33 PM**
> **Comment [2]:** Payor sources vary. Look at DHS 34 and 124.

2.3. Please provide your thoughts on the changes over the next five to ten years that will occur to the nature of the program and its services in moving to a new facility (this could be an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, etc.)

Will continue to focus on the most serious and persistent mentally ill population

> **Francis Pitts 4/10/15 2:38 PM**
> **Comment [3]:** Will there be further reductions in census? No…it has stabilized at 10,500 visits per year.

2.1. Where are your patients arriving from? How are they admitted? admitted (e.g., booked and processed prior to arriving, unscheduled arrival?; Admission interview & exam ideally will happen centrally or on-unit, etc.)

Multiple: police, family, sheriff, case managers, self-admission. Do not have any scheduled admissions

Security check, mini registration, nurse triage (inc initial medical screening), full registration (fiscal desk) PCS treatment

> **Francis Pitts 4/10/15 2:40 PM**
> **Comment [4]:** What % is from public safety vehicles vs walk-in? 70-80% police/ambulance

2.2. To where are they discharged? How?

They go to the acute inpatient, home or residence, or jail.

> **Francis Pitts 4/10/15 2:44 PM**
> **Comment [5]:** Is this the progression? Yes.

2.3. What is your current alos (average length of stay)? Are there significant outliers that lead to a different mlos (median length of stay)?

LOS 24 hrs max., AVOS 4 HRS.

> **Francis Pitts 4/10/15 2:44 PM**
> **Comment [6]:** What is alos in 18 observation beds? 24-48 hous

2.4. Who are your patients? Are they characterized by important cultural or socio-economic characteristics that should be considered in the design process?

SEE CHART

3. Please respond to the following Patient Profiles for **both Current and Projected** populations. The purpose of this information is to assist the planners in understanding any specific facilities requirements that would in turn assist you in caring for these individuals.

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3.1. the approximate percent split of the inpatient population that is/will be ambulatory and non-ambulatory

Current: mostly ambulatory, few non ambulatory

Future: same

3.2. What percentage of patient bedrooms or recliner bays should be HC accessible?

Need 20 recliners, 1 quiet room with couch

3.3. the percentage of the patients with physical transfer requirements and the type of transfer

Current: rare

Future: rare

the percentage of the patients with incontinence problems and the nature of these

Current: 1%

Future: 1%

3.4. Please provide the number or percentage of patients with the following diagnoses for your current and future patient populations:

% of patients with a primary diagnosis of:	Current	Future
Cognitive Impairment	xx	xx
Obsessive Compulsive Disorder	xx	xx
Neurological	xx	xx
Dual Diagnosis MH/MR	xx	xx
Dual Diagnosis (MH/Addictions)	xx	xx
Mood & Anxiety Disorders	xx	xx
Schizophrenia	xx	xx
Other mental illness related to aging	xx	xx
Significant co-existing medical condition	xx	xx
Others –		

3.5. Behavioral Characteristics: please identify the percentage of your patient population with a significant presentation of the following characteristics currently and in the future:

% of patients with the following behavioral characteristics:	Current	Future
Aggression towards others	xx	xx
Elopement risk	xx	xx

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Sexual inappropriate behaviors	xx	xx
Pica (Ingestion of non-food products)	xx	xx
Property destruction	xx	xx
Hydrophilia	xx	xx

3.6. Patient age: please identify:

	Current	Future
Male/Female split (approximate %-age)	xx	xx
Age Range	xx	xx
Average Age	xx	xx

xxx

4. Please provide a summary of key clinical activity on-unit by the professions listed below where specific services are delivered that will influence the facility/environment considerations. The comments you provide may relate to current services that will remain valid and necessary in the future environment or services that are not/cannot currently be provided that will be necessary in the future. Please consider the response in the context of the future patient profile.

Psychology – xx

General Medicine – xx

Psychiatry – xx

Social Work - xx

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Occupational Therapy – xx

Recreational Therapy - xx

5. List the main program elements (spaces or functions) of each area.   This includes key features of your program. Please focus also on elements that relate to shortcomings of your area in relation to your concept of ideal patient care services and patient and staff environments.

   5.1.   What does your ICRA suggest with respect to the number, nature and location of isolation rooms?

   1 room in PCS and 1 in Observation

> **Francis Pitts 4/9/15 5:07 PM**
> **Comment [7]:** Negative pressur?

   5.2.   Where are patient belongings stored or where should they be stored?

   Need area for PCS area/locker secured storage, these lockers need to be very large as many patients come in with bags of their only belongings and need to be kept.

   5.3.   Does the nursing/direct care staff have access to the housekeeping/janitors closets for cleaning supplies and for cleaning up the occasional spill?

   Need- same as adult

   5.4.   How are snacks and beverages delivered, stored, and distributed?

   Separate refrigerator is needed for sandwiches.

   We also need a room-lounge for police/sheriff to wait for patients.

> **Francis Pitts 4/10/15 2:46 PM**
> **Comment [8]:** Work stations for up to four officers.

   5.5.   Where should the staff break room be located?

   Located in the area

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5.6. Should staff lockers be provided? If so, where? How many? What size?

Yes, in the area, large to accommodate winter clothing

> **Francis Pitts 4/10/15 2:48 PM**
> **Comment [9]:** How many lockers? How many staff in break room at one time? 15 lockers 3-4

5.7. Do visitors, staff and patients require separate toilet facilities in common areas? (This would be in addition to the toilet rooms at patient bedrooms?)

yes

5.8. Based on the format of the clinical treatment program, how many Consultation Rooms are needed within the PCS? Adjacent to the PCS?

Consultation rooms 1, and 4 interview booths

> **Francis Pitts 4/10/15 2:52 PM**
> **Comment [10]:** For registration? Yes. Where? Between triage and recliners.

5.9. How many Soiled Utility/Soiled Linen Rooms are needed? Can they be combined?

one

5.10. How many Clean Utility/Clean Linen Rooms are needed? Can they be combined?

0

If PCS and Observation were back to back all clean/diryt could be shared.

5.11. Are Comfort Rooms, Snoezelin Rooms or Sensory Modulation Rooms needed? If so how many and where should they be located?

Comfort 1

5.12. What style of nursing station is desired?

Open in line of sight of all patients and waiting area

5.13. How many seclusion rooms will be needed? Do they need to be padded?

2

5.14. How many exam rooms are needed?

1

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6. Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

Internal operations:

Please specifically address the following issues:

Work Flow Functional Characteristics/ Shortcomings:	Comments
Medication Administration	Pyxis
Meal Service /Dining Style (e.g. trays, bulk, family style?)	All food is in the form of snacks
Food Preparation (on-unit, off-unit?)	no
Level of Supervision required on unit	Nurse manager
Level of Supervision off unit	xxx
Equipment Room	Yes, large!
Crash Cart	yes

7. Please comment on the following Program Policy Considerations:

Program Policy Consideration:	Comment:
Patient space access/restrictions related to:	
• On-unit Kitchen	no
• Dining Area	no
• Exit doors	xxx
• Bathrooms	Staff, patient, ADA, policy also need an ADA shower
Time out/seclusion room policy	xxx
Visual/Auditory observation requirements	Yes, need to have everything at line of sight
Family Visitation (on-unit/off-unit; restrictions, need for supervision, etc.)	No family visitation but should have a family conference room on unit.
Special (Assisted) Bathing Facilities	ADA shower
Shower	Need special showers for contamination/oil, gasoline, and other chemicals

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8. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

The main issues I would advocate for in the "future PCS" is a continued open environment. I'm against rooms (and most PES across the country don't have them..........or if they do, they don't deal in acuity/medical problems) and feel that our ability to keep an open milieu is what contributes to our excellent safety numbers.

A couple of side rooms (like we have) is nice for family meetings/privacy/issues with trauma informed care, etc.........We had talked about a back of alcove type rooms/spaces with see through walls to give the open sightlines, that also had the ability to smoke the glass for privacy so there would be more de-escalation space but still open design

The space we have right now is probably just about right. Assuming that we'll never get much lower than 8-9,000 per year, this space is not too much, nor too little. We had a larger space over on 32A when we were redesigning, and it had more safety concerns. similarly, a smaller place would lead to not enough space for people to de-escalate.

**The one new thing we should consider (if willing to budget for extra ancillary staff) is having a second ingress/egress point aside from the circle drive. This is an area of efficiency that we could improve upon.......with a secondary entrance. I think a true ambulance bay that is covered to the second entrance/exit would be grand.

I also support liberal camera coverage in a new facility, as well as the two restraint rooms. A seclusion room would also be nice if space permits. What about one true restraint room and one padded room that can be flipped to either true seclusion or restraint?

Otherwise, there isn't any space that I would "cut" from the current model...........and when comparing to other PES, I find our layout to be "state of the art", etc......

Please feel free to bring me in on any architech/remodeling discussions that you feel pertinent. I feel I have a lot to offer in this respect.

9. Please note any differing opinions that still exist at the conclusion of your discussions:

xxx

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10. Please describe any other anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Same as inpatient, need to increase use of IT, safety/security

10.1. Please note any differing opinions that still exist at the conclusion of your discussions:

11. Please list the titles of current staff and number of FTE's and Bodies in each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – i.e. hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

11.1. What are your direct care staffing ratios/patterns?

Please describe post-positions per shift. As an example, please change the following accordingly:
3 RN and 2 CAN/MHT's on 8 AM-8PM, plus unit sec'y,
3 RN and 2 CAN/MHT's on 8 PM-8AM

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
xxx	x	X	X	X	X	x

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
MH Tech's/ Certified Nurse Assistant's	x	X	X	X	X	X
SW	x	X	X	X	X	X
OT	x	X	X	X	X	X
Residents	X	X	X	X	X	X
Psychiatrist	X	X	X	X	X	X
Clinical Nurse Specialist	X	X	X	X	X	X
Nurse Manger	X	X	X	X	X	X
Unit Secretary	X	X	X	X	X	X
Medical Students	X	X	X	X	X	X
Case Mangers	X	X	X	X	X	X
Psychology (see note in item 4) which is correct?	X	X	X	X	X	X
Nurse Practitioner (see note in item 4) which is correct?	X	X	X	X	X	X

11.2.   What specific changes should we anticipate with respect to future staffing?

None

11.3.   Where should staff offices be located?

Medical director should be on the unit.

12. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s), regardless of whether these are currently achieved or not possible. These relationships may be a result of patient flow, material flows, or staff movements or supervision needs

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SAME AS THE ADULT AND CHILDRENS UNIT

Between (function/area)	And (function/area)	Reason

12.1.   Please note any differing opinions that still exist at the conclusion of your discussions:

13. Describe critical ideal future external adjacency relationships that each area has with other departments in the facility. These relationships may be a result of patient flow, materials flow, or staff movements

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR   REASON INDICATOR
1 - Directly next to   A - Patient movement
2 - Same floor   B - Staff movement
3 - Doesn't matter   C - Materials movement

Department	Closeness	Reason	Contacts/Day
NA			
SAME AS ADULT			

Please note any differing opinions that still exist at the conclusion of your discussions:

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14. Please list materials, space, personnel or other resources that you share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

15. What are the major risks that need to be managed for each patient cohort? What are the physical implications of same?

16. Please comment on the need (if appropriate) for the following Assistive Technology – Adaptive Equipment. Do you anticipate this to change, and if so, please briefly describe the nature of the change?

Assistive Technology-Adaptive Equipment	Need (e.g. high/moderate/low/no need):
Physical Transfer Equipment (Hoyer lifts etc)	NO
Respiration Equipment	no
Oxygen	YES/TANK
Tube feeding equipment	low
Special needs ambulation/transport (Electronic Scooters/mechanical tricycles etc.)	low
Communication Equipment	low
Specialized Bathing Equipment (Hoyer lifts etc.)	See above
Personal Duress Alarm System	yes
Other (please specify)	xxx

17. What are or will be the most critical decisions that will be made with respect to this project?

same

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18. What outcomes are most important for your inpatient unit's mission? What environmental
    variables do we suspect or know are most critical for achieving those outcomes?

    same

19. What applicable research or evidence do you have or know about which might impact how the
    project is developed or designed?

    same

20. This there any other information or data that you feel the planning team should be aware of that
    has not been requested by this questionnaire?

    same

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Zimmerman Architectural Studios BHD Questionnaire – Psychiatric Crisis Service (PCS)

1.6 Discuss wait times for inpatient beds and impact on hold times in PCS.

Figure 1. 2008-2014
PCS and Acute Adult Admissions

	2008	2009	2010	2011	2012	2013	2014
Acute Adult Admissions	2,524	2,337	2,254	1,843	1,650	1,489	1,093
PCS Admissions	12,505	12,894	13,443	13,151	12,672	11,644	10,698

Figure 2. 2008-2014
Percent of Time on Waitlist Status

2008 = 27%   2009 = 5%   2010 = 17%   2011 = 14%   2012 = 6%   2013 = 2.8%

Figure 3. 2008-2014
Patients on Hospital Transfer Waitlist
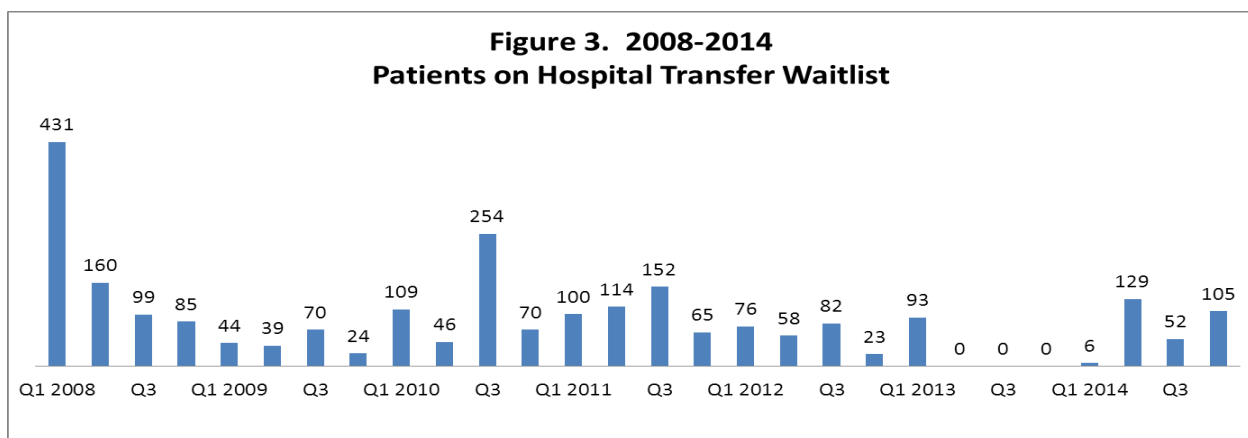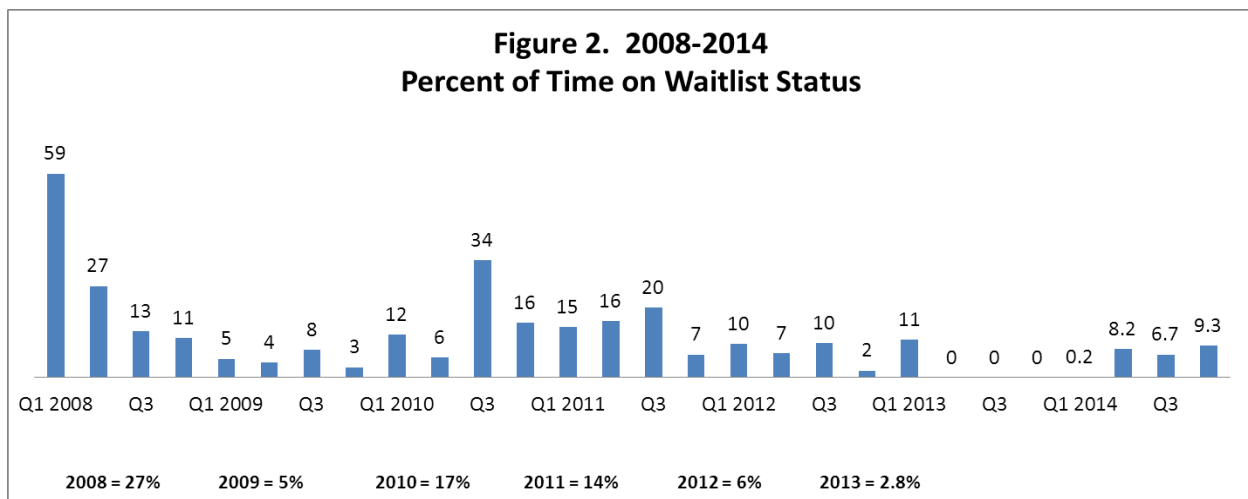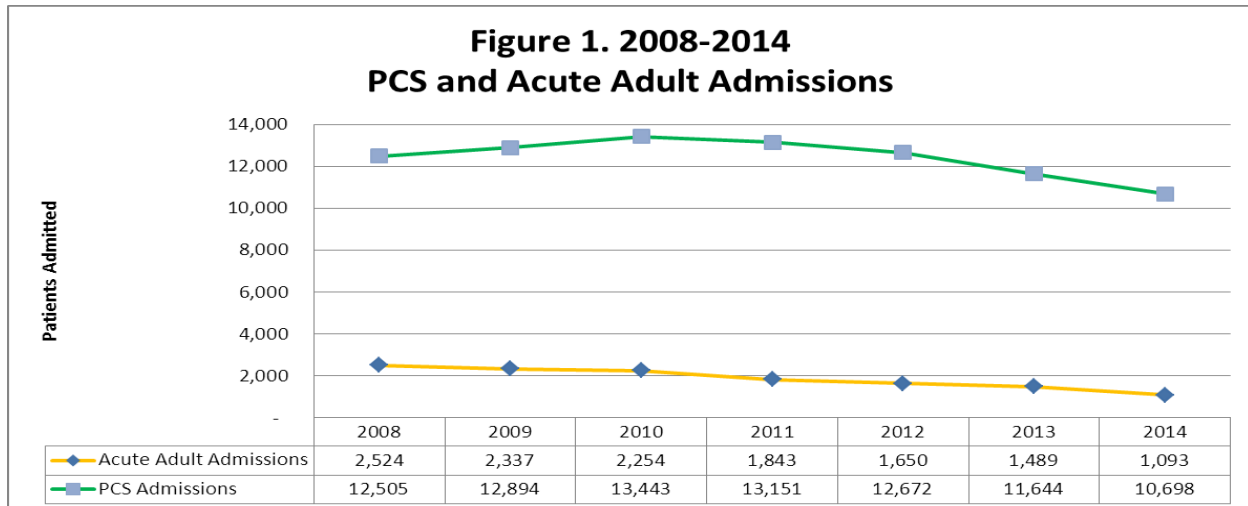
Figure 4. 2008 - 2014
Median Wait Time For Individuals Delayed   (Hours)
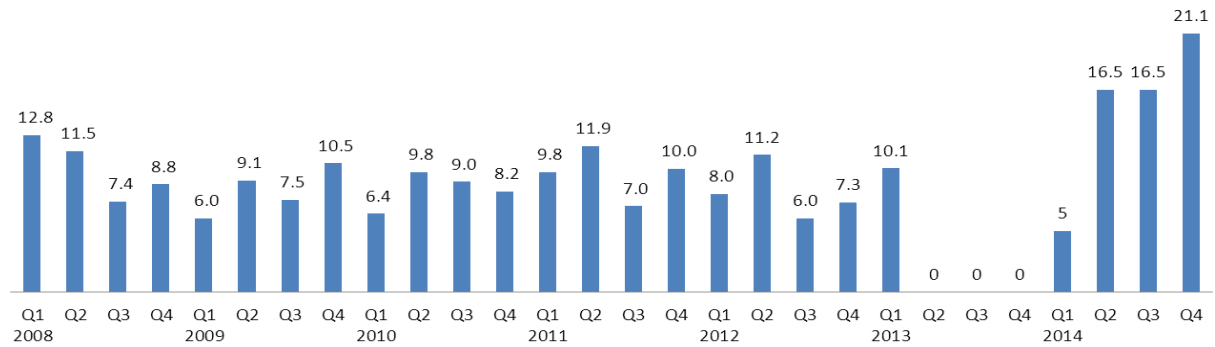
Figure 5. 2008-2014
Average Duration of Event (Hours)
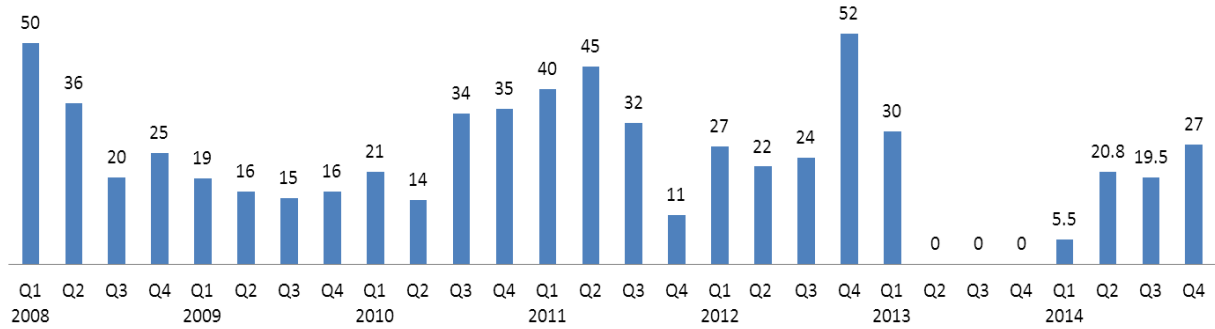
3.4 Please provide the number or percentage of patients with the following diagnosis:

2014 BHD PCS Patient Discharges by Primary Diagnosis
Time Period: (1/1/2014-12/31/2014)

Primary Diagnosis	Female	Male	Total
AC STRESS REAC EMOTIONAL DISTURB	9	2	11
ACUTE ALCOHOLIC INTOXI EPISODIC	0	1	1
ACUTE ALCOHOLIC INTOXI UNS	88	259	347
ADJUST DIS CONDUCT DISTURB	36	73	109
ADJUST DIS EMOT/CONDUCT DISTUR	68	79	147
ADJUSTMENT DISORDER ANXIETY	23	35	58
ADJUSTMENT DISORDER DEPRESSED	149	171	320
ADJUSTMENT DISORDER MIXED	209	232	441
ALCOHOL ABUSE UNSPEC	66	148	214
ALCOHOL PERSIST AMNESTIC DISORDER	0	1	1
ALCOHOL WDRAWAL DELIRIUM	0	1	1
ALCOHOL WITHDRAWAL	6	8	14
ALCOHOL-INDUCED DELUSIONS	1	0	1
ALCOHOL-INDUCED HALLUCINATIONS	0	2	2
ALCOHOL-INDUCED PERSIST DEMENTIA	0	1	1
AMPHETAMINE/RELATED DRUG ABUSE UNS	1	1	2
ANTISOCIAL PERSONALITY DISORDER	8	136	144
ANXIETY STATE UNSPECIFIED	45	33	78
ATTENTION DEFICIT DIS W HYPERACT	8	47	55
ATTENTION DEFICIT DIS WO HYPERACTV	4	9	13
AUTISTIC DISORDER CURR/ACTIVE	7	17	24
BEREAVEMENT UNCOMPLICATED	6	3	9
BIPOLAR DISORDER UNSPECIFIED	77	73	150
BIPOLAR I DIS DEPRESS SEV NO PSYCH	4	4	8
BIPOLAR I DIS DEPRESSED MILD	4	0	4
BIPOLAR I DIS DEPRESSED MODERATE	11	6	17
BIPOLAR I DIS DEPRESSED SEV PSYCH	4	2	6
BIPOLAR I DIS DEPRESSED UNS	5	5	10
BIPOLAR I DIS MANIC MILD	11	7	18
BIPOLAR I DIS MANIC MODERATE	9	9	18
BIPOLAR I DIS MANIC SEV NO PSYCH	12	6	18
BIPOLAR I DIS MANIC SEV PSYCH	44	45	89
BIPOLAR I DIS MANIC UNS	32	25	57
BIPOLAR I DIS MIXED MODERATE	3	0	3
BIPOLAR I DIS MIXED SEV NO PSYCH	4	3	7
BIPOLAR I DIS MIXED SEV PSYCH	2	5	7
BIPOLAR I DIS MIXED UNS	20	13	33
BIPOLAR I DIS SINGLE EPI UNS	0	1	1
BIPOLAR I DISORDER UNSPECIFIED	19	21	40
BORDERLINE PERSONALITY DIS	123	15	138
CANNABIS ABUSE UNS	4	25	29
CANNABIS DEPENDENCE UNS	3	14	17
COCAINE ABUSE UNS	26	75	101
COCAINE DEPENDENCE UNS	63	78	141
COMBO DRUG DEPEND EX OPIOIDS REMISS	0	1	1
COMBO DRUG DEPEND EX OPIOIDS UNS	65	211	276
CONDUCT DISORDER ADOLESCENT ONSET	9	23	32
CONDUCT DISORDER CHILDHOOD ONSET	5	35	40
CONVERSION DISORDER	2	0	2
DEFERRED	19	40	59
DELIRIUM IN OTHER CONDITIONS	10	4	14
DELUSIONAL DISORDER	10	3	13
DEMENTIA UNSPEC W BEHAV DISTURBANCE	2	6	8
DEMENTIA W BEHAVIORAL DISTURBANCE	4	5	9
DEPENDENT PERSONALITY DISORDER	2	0	2
DEPRESSIVE DISORDER OTHER	505	370	875
DEPRESSIVE TYPE PSYCHOSIS	6	4	10
DRUG WITHDRAWAL	3	2	5
DRUG-INDUCD DELIRIUM	0	2	2
DRUG-INDUCED MOOD DISORDER	56	114	170
DRUG-INDUCED PSYCHOT DELUSIONS	0	3	3
DRUG-INDUCED PSYCHOT HALLUCINATN	8	10	18
DYSTHYMIC DISORDER	2	1	3
EATING DISORDER UNSPECIFIED	2	0	2
FACTITIOUS DISORDER W PSYCH SYMPTOM	0	1	1
FETISHISM	0	2	2
GENERALIZED ANXIETY DISORDER	8	7	15
HISTORY SCHIZOPHRENIA	0	3	3
IDIOSYNCRATIC ALCOHOL INTOXICATION	51	181	232
INTERMITTENT EXPLOSIVE DISORDER	3	21	24
LATENT SCHIZOPHRENIA CHRONIC	0	1	1
LATENT SCHIZOPHRENIA UNS	0	2	2
MAJ DEPRESS DIS RECUR EPI SEV	48	23	71
MAJ DEPRESS DIS RECUR EPI SEV PSYCH	15	13	28

Primary Diagnosis	Female	Male	Total
MAJ DEPRESS DIS RECURR EPI MILD	9	10	19
MAJ DEPRESS DIS RECURR EPI MOD	54	20	74
MAJ DEPRESS DIS RECURR EPI UNS	22	9	31
MAJ DEPRESS DIS SGL EPI MODERATE	18	18	36
MAJ DEPRESS DIS SGL EPI SEV	38	22	60
MAJ DEPRESS DIS SGL EPI SEV PSYCH	8	6	14
MAJ DEPRESS DIS SINGLE EPI MILD	2	6	8
MILD INTELLECTUAL DISABILITIES	4	4	8
MODERATE INTELLECTUAL DISABILITIES	3	2	5
MOOD DISORDER IN OTHER CONDITIONS	0	1	1
NO DIAGNOSIS	93	172	265
No Entry	4	12	16
OBSESSIVE COMPULSIVE DISORDERS	0	8	8
OPIOID ABUSE UNS	5	12	17
OPIOID TYPE DEPENDENCE CONTINUOUS	0	2	2
OPIOID TYPE DEPENDENCE UNS	26	71	97
OPPOSITIONAL DEFIANT DISORDER	69	51	120
OTH ALTERATION CONSCIOUSNESS	1	2	3
OTH DISORDERS IMPULSE CONTROL	0	6	6
OTH EMOTIONAL DISTURBANCE CHILDHOOD	0	2	2
OTH MENTAL PROBLEMS	23	27	50
OTH MIXED/UNS DRUG ABUSE UNS	1	4	5
OTH PSYCHOLOGICAL/PHYSICAL STRESS	3	4	7
OTH/UNS ALCOHOL DEPENDENCE UNS	82	265	347
OTH/UNS REACTIVE PSYCHOSIS	5	15	20
OTH/UNSP BIPOLAR DISORDER OTHER	7	1	8
OTHER ALCOHOL-INDUCED MENTAL DIS	4	20	24
OTHER DRUG DEPENDENCE UNS	2	5	7
OTHER PERVASIVE DEVELOP DIS ACTIVE	2	4	6
PANIC DISORDER WO AGORAPHOBIA	0	2	2
PATHOLOGICAL DRUG INTOXICATION	1	4	5
PATHOLOGICAL GAMBLING	0	1	1
PERSON FEIGNING ILLNESS	0	15	15
POSTTRAUMATIC STRESS DISORDER	48	47	95
SCHIZOAFFECTIVE DIS CHRONIC	2	1	3
SCHIZOAFFECTIVE DIS UNSPEC	305	394	699
SCHIZOPHREN CATATONIC UNS	1	1	2
SCHIZOPHREN DISORGANIZED CHRONIC	1	11	12
SCHIZOPHREN DISORGANIZED UNS	11	13	24
SCHIZOPHREN PARANOID CHRONIC	22	23	45
SCHIZOPHREN PARANOID UNS	48	88	136
SCHIZOPHREN SIMPLE UNS	0	3	3
SCHIZOPHRENIC DIS RESIDUAL UNS	0	4	4
SCHIZOPHRENIFORM DISORDER UNS	1	4	5
SED/HYP/ANX ABUSE UNS	1	1	2
SED/HYP/ANX DEPEND UNS	0	2	2
SENILE DEMENTIA UNCOMPLICATED	2	1	3
SEVERE INTELLECTUAL DISABILITIES	1	2	3
SOCIALIZED CONDUCT DISORDER SEVERE	0	1	1
UNS ADJUST REAC	53	79	132
UNS DELAY IN DEVELOPMENT	2	2	4
UNS DISSOCIATIVE DISORDER/REACTION	0	1	1
UNS DISTURBANCE CONDUCT	19	58	77
UNS DRUG-INDUCD MENTAL DISORDER	1	8	9
UNS IMPULSE CONTROL DISORDER	58	110	168
UNS INTELLECTUAL DISABILITIES	6	5	11
UNS MENTAL/BEHAVIORAL PROBLEM	21	39	60
UNS NONORGANIC SLEEP DISORDER	2	1	3
UNS PERSIST MENT DIS IN OT COND	1	1	2
UNS PERSONALITY DISORDER	26	40	66
UNS SCHIZOPHRENIA	127	254	381
UNS SCHIZOPHRENIA CHRONIC	0	5	5
UNS TRANSIENT MENT DIS IN OT COND	0	1	1
UNSP NONPSYCHOTIC MENTAL DIS	1	2	3
UNSP PERVASIVE DEVELOP DIS ACTIVE	6	10	16
UNSPEC EPISODIC MOOD DISORDER	825	855	1,680
UNSPEC PARANOID STATE	1	0	1
UNSPECIFIED PSYCHOSIS	317	599	916
VASC DEMENTIA W DEPRESS MOOD	0	1	1
VASCULAR DEMENTIA UNCOMPL	4	0	4
Psychiatric Crisis Service Total	**4,448**	**6,249**	**10,697**

Zimmerman Architectural Studios BHD Questionnaire – Acute Adult Inpatient Service

2.2 To where are they discharged?

2014 BHD Acute Adult Patient Disposition Time Period: 1/1/2014-12/31/2014		
Disposition	N	%
Home/Self-care - Home	766	69.1
Home/Self-care-Crisis Stabilizatn House	95	8.6
Against Medical Advice	55	5.0
Home/Self-care-CBRF (group home)	37	3.3
Home/Self-care-DSD Crisis Respite	20	1.8
Hospital-Medical Care Facility	17	1.5
Home/Self-care-Crisis Response/Mobile	14	1.3
Home/Self-care-CSP	14	1.3
Jail	14	1.3
Home/Self-care - Case Management	13	1.2
Home/Self-care-Belwood	11	1.0
BHD Rehabilitation Central	9	0.8
Home/Self-care-TCM	5	0.5
Home/Self-care-SAIL	4	0.4
Hospital-Aurora Psych	4	0.4
Hospital-Roger's	4	0.4
Home/Self-care-CJF (Crim Justice) Psych	3	0.3
Home/Self-care-Supported Apartment	3	0.3
Hospital-State Hospitals	3	0.3
Hospital-VA	3	0.3
Home/Self-Care-Access Clinic	2	0.2
Home/Self-care-AODA Treatment Program	2	0.2
Home/Self-care-CRC South	2	0.2
Home/Self-care-OP Psych/Therapy Srvcs	2	0.2
Rehab Facility	2	0.2
BHD Hilltop	1	0.1
Home/Self-care-CRC North	1	0.1
Home/Self-care-Day Treatment	1	0.1
Hospital-BHD Acute Inpatient	1	0.1
Skill or Intermediate Care-Assist Living	1	0.1
Total	1109	100.0

2.3 What is your current ALOS? Median LOS?

Acute Adult Median and Average Length of Stay

	2007	2008	2009	2010	2011	2012	2013	2014
ALOS	13.2	14.0	14.7	14.8	15.3	15.8	14.7	15.0
Median LOS	7.0	7.0	7.0	7.0	8.0	8.0	8.0	9.0
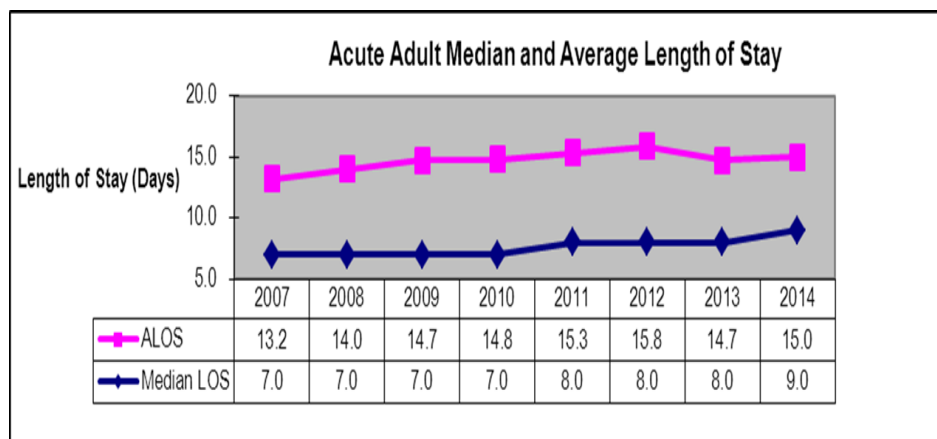
2.4 Who are your patients?

2014 BHD Acute Adult Admissions - Patient Insurance Coverage		
Insurance	N	%
Medicaid	507	46.4
Medicare	250	22.9
Self Pay	121	11.1
T-18 HMO	105	9.6
Commercial Insurance	87	8.0
Other	12	1.1
Family Care HMO	11	1.0
Commercial HMO	0	0.0
Total	1093	100.0

3.4 Please provide the number or percentage of patients with the following diagnosis.

2014 BHD Acute Adult Patient Discharges by Primary Diagnosis Time Period: (1/1/2014-12/31/2014)			
Diagnosis	Female	Male	Total
ADJUST DIS EMOT/CONDUCT DISTUR	2	5	7
ADJUSTMENT DISORDER ANXIETY	1	1	2
ADJUSTMENT DISORDER DEPRESSED	3	3	6
ADJUSTMENT DISORDER MIXED	2	3	5
ALCOHOL ABUSE UNSPEC	0	1	1
ALCOHOL-INDUCED PERSIST DEMENTIA	0	1	1
ANTISOCIAL PERSONALITY DISORDER	0	2	2
ANXIETY STATE UNSPECIFIED	2	0	2
AUTISTIC DISORDER CURR/ACTIVE	1	0	1
BIPOLAR DISORDER UNSPECIFIED	18	11	29
BIPOLAR I DIS DEPRESS SEV NO PSYCH	2	1	3
BIPOLAR I DIS DEPRESSED MODERATE	1	1	2
BIPOLAR I DIS DEPRESSED SEV PSYCH	1	0	1
BIPOLAR I DIS DEPRESSED UNS	0	1	1
BIPOLAR I DIS MANIC MILD	2	2	4
BIPOLAR I DIS MANIC MODERATE	1	6	7
BIPOLAR I DIS MANIC SEV NO PSYCH	8	8	16
BIPOLAR I DIS MANIC SEV PSYCH	62	67	129
BIPOLAR I DIS MANIC UNS	3	8	11
BIPOLAR I DIS MIXED MODERATE	2	0	2
BIPOLAR I DIS MIXED SEV NO PSYCH	1	1	2
BIPOLAR I DIS MIXED SEV PSYCH	4	2	6
BIPOLAR I DIS MIXED UNS	1	0	1
BIPOLAR I DISORDER UNSPECIFIED	6	3	9
BORDERLINE PERSONALITY DIS	5	3	8
COCAINE ABUSE UNS	1	0	1
COMBO DRUG DEPEND EX OPIOIDS UNS	2	1	3
CONVERSION DISORDER	1	0	1
DEFERRED	3	1	4
DELIRIUM IN OTHER CONDITIONS	1	1	2
DELUSIONAL DISORDER	2	0	2
DEMENTIA DUE TO HEAD TRAUMA, OR HIV DISE	0	1	1
DEPENDENT PERSONALITY DISORDER	0	1	1
DEPRESSIVE DISORDER OTHER	9	7	16
DEPRESSIVE TYPE PSYCHOSIS	0	1	1
DRUG WITHDRAWAL	0	1	1
DRUG-INDUCD DELIRIUM	1	1	2
DRUG-INDUCED MOOD DISORDER	3	8	11
DRUG-INDUCED PSYCHOT DELUSIONS	1	1	2
DYSTHYMIC DISORDER	0	1	1
GENERALIZED ANXIETY DISORDER	0	1	1
MAJ DEPRESS DIS RECUR EPI SEV	9	11	20
MAJ DEPRESS DIS RECUR EPI SEV PSYCH	3	6	9
MAJ DEPRESS DIS RECURR EPI MILD	0	1	1
MAJ DEPRESS DIS RECURR EPI MOD	4	1	5
MAJ DEPRESS DIS RECURR EPI UNS	0	1	1
MAJ DEPRESS DIS SGL EPI MODERATE	2	1	3
MAJ DEPRESS DIS SGL EPI SEV	2	0	2
MAJ DEPRESS DIS SGL EPI SEV PSYCH	4	1	5
MENTAL DISORDER ANTEPART	1	0	1
OPIOID ABUSE UNS	1	0	1
OTH MENTAL PROBLEMS	1	2	3
OTH/UNS ALCOHOL DEPENDENCE UNS	1	3	4
OTH/UNS REACTIVE PSYCHOSIS	1	0	1
OTH/UNSP BIPOLAR DISORDER OTHER	0	1	1
POSTTRAUMATIC STRESS DISORDER	0	2	2
SCHIZOAFFECTIVE DIS UNSPEC	166	203	369
SCHIZOPHREN CATATONIC UNS	0	3	3
SCHIZOPHREN DISORGANIZED CHRONIC	0	2	2
SCHIZOPHREN DISORGANIZED UNS	1	2	3
SCHIZOPHREN PARANOID CHRONIC	11	17	28
SCHIZOPHREN PARANOID UNS	10	29	39
SCHIZOPHRENIFORM DISORDER UNS	3	0	3
SHARED PSYCHOTIC DISORDER	1	0	1
UNS DRUG-INDUCD MENTAL DISORDER	0	1	1
UNS IMPULSE CONTROL DISORDER	1	4	5
UNS PERSONALITY DISORDER	1	5	6
UNS SCHIZOPHRENIA	19	81	100
UNSPEC EPISODIC MOOD DISORDER	36	27	63
UNSPECIFIED PSYCHOSIS	52	66	118
VASCULAR DEMENTIA UNCOMPL	1	0	1
Acute Adult Total	**483**	**626**	**1109**

3.5 Behavioral characteristics

INCIDENTS	2010		2011		2012		2013		2014	
	N	%	N	%	N	%	N	%	N	%
AGGRESSION - PT/PT	73	10.6	73	12.3	60	10.6	102	17.4	109	19.0
FALL - PATIENT	182	26.4	143	24.1	106	18.8	102	17.4	98	17.1
AGGRESSION - PT/EMP	73	10.6	81	13.7	71	12.6	70	11.9	74	12.9
MEDICAL EMERGENCY - CODE 4	68	9.9	60	10.1	64	11.3	45	7.7	48	8.4
OTHER	59	8.6	47	7.9	57	10.1	49	8.3	43	7.5
INJURY - SELF INFLICTED	40	5.8	31	5.2	30	5.3	33	5.6	41	7.1
INJURY - ACCIDENTAL	43	6.2	37	6.2	46	8.2	33	5.6	28	4.9
CAREGIVER MISCONDUCT ALLEGATION	24	3.5	14	2.4	17	3.0	23	3.9	24	4.2
PROPERTY DAMAGE	12	1.7	14	2.4	17	3.0	13	2.2	23	4.0
INJURY - S & R INJURY	17	2.5	11	1.9	4	0.7	21	3.6	18	3.1
SEXUALLY INAPPROPRIATE BEHAVIOR	16	2.3	14	2.4	29	5.1	12	2.0	14	2.4
CONTRABAND	19	2.8	22	3.7	10	1.8	23	3.9	13	2.3
MISSING PROPERTY/THEFT	20	2.9	16	2.7	13	2.3	18	3.1	11	1.9
KNOWN OR ALLEGED SEXUAL CONTACT	8	1.2	10	1.7	1	0.2	9	1.5	6	1.0
EXPOSURE TO INFECTION	4	0.6	5	0.8	6	1.1	10	1.7	6	1.0
ELOPEMENT FROM LOCKED UNIT	9	1.3	7	1.2	11	2.0	10	1.7	6	1.0
CHOKING	2	0.3	2	0.3	4	0.7	5	0.9	4	0.7
CONFIDENTIALITY BREACH	3	0.4	-	-	-	-	1	0.2	3	0.5
SUICIDE ATTEMPT	7	1.0	-	-	5	0.9	1	0.2	2	0.3
Medication Variance Causing Harm	-	-	-	-	-	-	-	-	1	0.2
FALL - EMPLOYEE/VISITOR	3	0.4	2	0.3	8	1.4	6	1.0	1	0.2
ELOPEMENT FROM ESCORT	2	0.3	2	0.3	1	0.2	1	0.2	1	0.2
FIRE	-	-	-	-	-	-	-	-	-	-
ADVERSE DRUG REACTION	-	-	-	-	3	0.5	-	-	-	-
BURN	-	-	1	0.2	-	-	-	-	-	-
FAILURE TO RETURN TO UNIT	2	0.3	-	-	-	-	-	-	-	-
HAZ.MAT./ENVIRONMENTAL CONTAM.	1	0.1	-	-	1	0.2	-	-	-	-
MEDICAL DEVICE/EQUIPMENT PROBLEM	2	0.3	1	0.2	-	-	-	-	-	-
TOTAL INCIDENTS	**689**	**100.0**	**593**	**100.0**	**564**	**100.0**	**587**	**100.0**	**574**	**100.0**

Table title: **2010 - 2014 BHD Incidents - Acute Adult**

3.6 Patient age

Average Age: 39.0 years

Age Range: 18 – 94 years

Gender: 56.4% male, 43.6% female

Zimmerman Architectural Studios BHD Questionnaire – Child Adolescent Inpatient Service

2.2 To where are they discharged?

2014 BHD CAIS Patient Disposition Time Period: 1/1/2014-12/31/2014		
Disposition	N	%
Home/Self-care - Home	776	81.6
Home/Self-care-CBRF (group home)	56	5.9
Home/Self-care - Case Management	33	3.5
Hospital-Roger's	28	2.9
Hospital-Medical Care Facility	20	2.1
Hospital-Aurora Psych	18	1.9
Jail	9	0.9
Home/Self-care-OP Psych/Therapy Srvcs	3	0.3
Home/Self-care-Crisis Response/Mobile	2	0.2
Home/Self-care-Crisis Stabilizatn House	2	0.2
Home/Self-care-CSP	2	0.2
Home with home health service	1	0.1
Home/Self-care-DSD Crisis Respite	1	0.1
Total	951	100.0

2.3 What is your current ALOS?
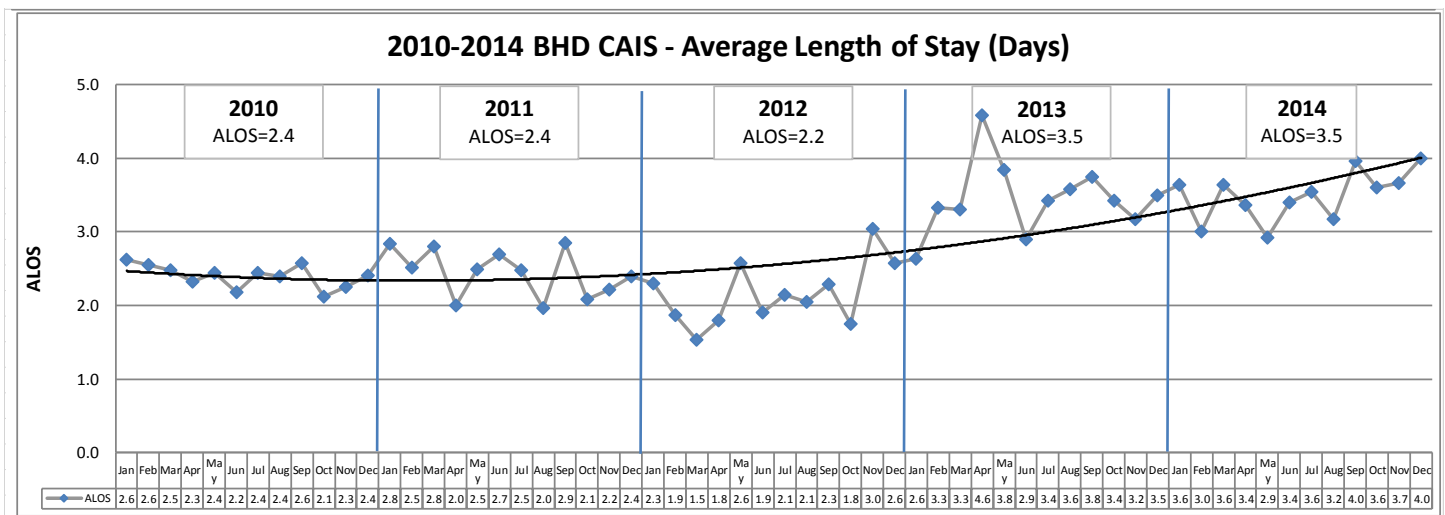
Who are your patients?

2014 BHD CAIS Admissions - Patient Insurance Coverage		
Insurance	N	%
Medicaid	775	81.5
Commercial Insurance	143	15.0
Commercial HMO	15	1.6
Self Pay	14	1.5
Other	4	0.4
Medicare	0	0.0
T-18 HMO	0	0.0
Family Care HMO	0	0.0
Total	951	100.0

3.4 Please provide the number or percentage of patients with the following diagnosis:

2014 BHD CAIS Patient Discharges by Primary Diagnosis Time Period: (1/1/2014-12/31/2014)			
Diagnosis	Female	Male	Total
AC STRESS REAC EMOTIONAL DISTURB	1	0	1
ADJUST DIS CONDUCT DISTURB	2	0	2
ADJUST DIS EMOT/CONDUCT DISTUR	42	37	79
ADJUSTMENT DISORDER ANXIETY	1	1	2
ADJUSTMENT DISORDER DEPRESSED	17	10	27
ADJUSTMENT DISORDER MIXED	14	13	27
AMPHETAMINE/RELATED DRUG ABUSE UNS	1	0	1
ANXIETY STATE UNSPECIFIED	3	3	6
ATTENTION DEFICIT DIS W HYPERACT	5	7	12
AUTISTIC DISORDER CURR/ACTIVE	1	1	2
BIPOLAR DISORDER UNSPECIFIED	3	5	8
BIPOLAR I DIS DEPRESS SEV NO PSYCH	2	1	3
BIPOLAR I DIS DEPRESSED MODERATE	2	1	3
BIPOLAR I DIS DEPRESSED SEV PSYCH	0	1	1
BIPOLAR I DIS MANIC MODERATE	1	1	2
BIPOLAR I DIS MANIC SEV NO PSYCH	4	0	4
BIPOLAR I DIS MANIC SEV PSYCH	2	2	4
BIPOLAR I DIS MANIC UNS	1	0	1
BIPOLAR I DIS MIXED MODERATE	3	2	5
BIPOLAR I DIS MIXED SEV NO PSYCH	6	1	7
BIPOLAR I DIS MIXED UNS	1	1	2
BIPOLAR I DISORDER UNSPECIFIED	6	1	7
BORDERLINE PERSONALITY DIS	5	0	5
CANNABIS ABUSE UNS	0	2	2
CONDUCT DISORDER ADOLESCENT ONSET	3	4	7
CONDUCT DISORDER CHILDHOOD ONSET	1	11	12
CONVERSION DISORDER	0	1	1
DEFERRED	1	0	1
DEPRESSIVE DISORDER OTHER	61	32	93
DEPRESSIVE TYPE PSYCHOSIS	2	3	5
DRUG-INDUCED MOOD DISORDER	0	1	1
GENERALIZED ANXIETY DISORDER	3	2	5
INTERMITTENT EXPLOSIVE DISORDER	0	1	1
MAJ DEPRESS DIS RECUR EPI SEV	12	9	21
MAJ DEPRESS DIS RECUR EPI SEV PSYCH	1	1	2
MAJ DEPRESS DIS RECURR EPI MILD	0	1	1
MAJ DEPRESS DIS RECURR EPI MOD	13	4	17
MAJ DEPRESS DIS RECURR EPI UNS	4	1	5
MAJ DEPRESS DIS SGL EPI MODERATE	6	1	7
MAJ DEPRESS DIS SGL EPI SEV	32	9	41
MAJ DEPRESS DIS SGL EPI SEV PSYCH	6	2	8
MAJ DEPRESS DIS SINGLE EPI MILD	1	0	1
OPPOSITIONAL DEFIANT DISORDER	11	9	20
OTH EMOTIONAL DISTURBANCE CHILDHOOD	0	2	2
OTH MIXED/UNS DRUG ABUSE UNS	0	1	1
POSTTRAUMATIC STRESS DISORDER	12	12	24
SCHIZOAFFECTIVE DIS UNSPEC	1	4	5
SCHIZOPHREN DISORGANIZED CHRONIC	0	1	1
SCHIZOPHREN PARANOID CHRONIC	1	0	1
SCHIZOPHREN PARANOID UNS	0	1	1
SCHIZOPHRENIFORM DISORDER UNS	1	2	3
UNS ADJUST REAC	3	1	4
UNS DISTURBANCE CONDUCT	3	12	15
UNS IMPULSE CONTROL DISORDER	4	2	6
UNS SCHIZOPHRENIA	1	0	1
UNSP NONPSYCHOTIC MENTAL DIS	0	1	1
UNSP PERVASIVE DEVELOP DIS ACTIVE	0	2	2
UNSPEC EPISODIC MOOD DISORDER	223	171	394
UNSPECIFIED PSYCHOSIS	5	23	28
Total	**534**	**417**	**951**

3.5 Behavioral characteristics

INCIDENTS	2010		2011		2012		2013		2014	
	N	%	N	%	N	%	N	%	N	%
AGGRESSION - PT/EMP	11	17.7	18	17.5	10	18.5	10	12.2	18	23.1
AGGRESSION - PT/PT	10	16.1	16	15.5	7	13.0	13	15.9	12	15.4
FALL - PATIENT	2	3.2	5	4.9	8	14.8	17	20.7	6	7.7
INJURY - SELF INFLICTED	6	9.7	9	8.7	6	11.1	3	3.7	5	6.4
CAREGIVER MISCONDUCT ALLEGATION	-	-	4	3.9	3	5.6	3	3.7	4	5.1
OTHER	4	6.5	12	11.7	5	9.3	13	15.9	4	5.1
PROPERTY DAMAGE	5	8.1	3	2.9	1	1.9	1	1.2	4	5.1
INJURY - ACCIDENTAL	7	11.3	8	7.8	4	7.4	5	6.1	4	5.1
INJURY - S & R INJURY	3	4.8	5	4.9	1	1.9	-	-	4	5.1
ELOPEMENT FROM LOCKED UNIT	2	3.2	-	-	-	-	1	1.2	3	3.8
MEDICAL EMERGENCY - CODE 4	1	1.6	11	10.7	1	1.9	9	11.0	3	3.8
SEXUALLY INAPPROPRIATE BEHAVIOR	2	3.2	2	1.9	1	1.9	1	1.2	2	2.6
MISSING PROPERTY/THEFT	1	1.6	1	1.0	3	5.6	3	3.7	2	2.6
EXPOSURE TO INFECTION	-	-	2	1.9	-	-	1	1.2	2	2.6
SUICIDE ATTEMPT	2	3.2	2	1.9	-	-	1	1.2	1	1.3
CONTRABAND	4	6.5	1	1.0	1	1.9	-	-	1	1.3
Confidentiality Breach	-	-	-	-	-	-	-	-	1	1.3
Fire	-	-	-	-	-	-	-	-	1	1.3
FALL - EMPLOYEE/VISITOR	-	-	1	1.0	1	1.9	-	-	1	1.3
MEDICAL DEVICE/EQUIPMENT PROBLEM	-	-	-	-	-	-	1	1.2	-	-
CHOKING	-	-	-	-	-	-	-	-	-	-
HAZ.MAT./ENVIRONMENTAL CONTAM.	-	-	-	-	-	-	-	-	-	-
KNOWN OR ALLEGED SEXUAL CONTACT	2	3.2	3	2.9	2	3.7	-	-	-	-
TOTAL INCIDENTS	62	100.0	103	100.0	54	100.0	82	100.0	78	100.0

2010 - 2014 BHD Incidents - CAIS

3.6 Patient age

Average Age: 14.9 years

Age Range: 6 – 17 years

Gender: 56.2% female, 43.8% male

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
HFS 61.71/61.79.sav (date) (12-91) (Updated 1-06)

STATE OF WISCONSIN

SURVEY REPORT
FOR INPATIENT TREATMENT PROGRAMS
HFS 61.70-61.72, 61.74, 61.78, 61.79

To Program Personnel:

This application is to verify that the mental health inpatient program complies with Wisconsin Administrative codes HFS 61.71 and HFS 61.79.

After review of the submitted application, a preliminary determination will be made as to the unit's eligibility for certification. If eligibility appears feasible, an on-site visit will be scheduled and certification status determined.

If no significant deficiencies are found by the site visit, a certificate will be issued. If significant deficiencies are identified, the applicant will be afforded an opportunity to develop a plan of correction to complete compliance.

Please read these directions carefully before completing this questionnaire and respond to every item. The areas on the right side of the survey are for the surveyor's use. Where "verification" is required in the questionnaire, list the type of policy document or materials that will be presented to verify the statement in question. DO NOT forward the actual documents or material with the questionnaire but be sure that such are available for review at the time of the on-site survey. Duplicate the staff addendums as needed.

This survey document is divided into three distinct parts. Part I is a general survey and also pertains to adult inpatient treatment programs. Part II is particular to children and adolescents and must be completed in addition to Part I if you treat individuals less than 18 years of age for more than evaluation purposes and if these individuals exceed 21 total days within a 3 month time span. Part III is entitled "Inpatient Mental Health Staff," to be completed as appropriate. The full certification standards for mental health inpatient treatment are in a separate document.

Regarding HFS 61.74 - Emergency Care - Inpatient, Mental Health. Inherent within the inpatient survey document(s) is the concept of emergency care which by State Statute is required for all counties. It is not the purpose of these standards or the 51.42/437 Board to duplicate services. Therefore, if emergency services have been provided by or contracted by the Board or you do not wish to be certified for emergency services (meaning providing emergency mental health inpatient care for all county residents or contracted service area(s), please make note of this in the "Comments Section." Otherwise, successful verification of the inpatient survey document will automatically result in certification for inpatient as well as emergency inpatient mental health treatment.

This questionnaire was completed by:

Program Person Jennifer M. Bergersen, MSW	Phone 414-257-7473
Title Chief Quality & Compliance Officer	Date 09-08-14
Official Name of Facility Milwaukee County Behavioral Health Division	
Address 9455 Watertown Plank Rd. Milwaukee, Wisconsin 53226	

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that I will comply with all laws, rules, and regulations governing inpatient mental health, including HFS 61.70-61.72, 61.74, 61.78, 61.79, HFS 92, HFS 94.

Date 09-08-14 *09-08-14*	Administrator's Signature in Full Jennifer M. Bergersen, MSW *(signature)*
Date of On-Site Survey	Surveyor
Date of On-Site Survey	Surveyor

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
HFS 61.71/61.79.sav (date) (12-91) (Updated 1-06)

STATE OF WISCONSIN

PART I
SURVEY REPORT
INPATIENT TREATMENT PROGRAMS
HFS 61.70 - 61.72
(Includes General Requirements and Adult Program Includes
Standards)

HFS 61.71(1) - REQUIRED PERSONNEL A written policy that meets or exceeds the following minimum staffing requirements	FOR SURVEYORS USE ONLY
(a) Psychiatry 1. Psychiatrist -Medical Director ☒YES ☐NO 2. .8 hour per patient per week ☒YES ☐NO 3. Available daily and in emergencies ☒YES ☐NO	+ ( ) - ( )
(b)1 Nursing Services 1. At least one RN on day and evening shift ☒YES ☐NO 2. At least one RN or LPN on night shift ☒YES ☐NO 3. .32 hour per patient per day (2.24 hour per week) on day shifts ☒YES ☐NO 4. .16 hour per patient per day (1.12 per week) evening and night shifts ☒YES ☐NO	+ ( ) - ( )
(b)2 Aides and paraprofessionals 1. 1.24 hours per patient per day ☒YES ☐NO 2. At least one aide or other supervising staff person on duty in each ward when patients are present ☒YES ☐NO	+ ( ) - ( )
(c) Activity Therapy 1. 1.6 hours per patient per week ☒YES ☐NO 2. At least one full-time OTR ☒YES ☐NO 3. At least one COTA (or activity or art therapist) ☒YES ☐NO 4. Does OTR serve other units in the facility? ☐YES ☒NO 5. Do you have a work program (under the supervision of an OTR or vocational rehabilitation counselor)? ☐YES ☒NO	+ ( ) - ( )
(d) Social Services 1. .8 hour per patient per week ☒YES ☐NO 2. At least one MSW ☒YES ☐NO 3. Other MSW, BSW, or BSS staff ☒YES ☐NO	+ ( ) - ( )
(e) Psychological Services 1. .8 hour per patient per week ☒YES ☐NO 2. Licensed clinical psychologist ☒YES ☐NO	+ ( ) - ( )

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
HFS 61.71/61.79.sav (date) (12-91) (Updated 1-06)

STATE OF WISCONSIN

Documentation for personnel requirements:	
(2) PROGRAM CONTENT (a) Therapeutic Milieu 1. Written policy statement that describes overall program philosophy and design consistent with requirements for program content, including HFS 61.70-72, 61.74, HFS 92, HFS 94, and other applicable statutes and regulations. ☒YES ☐NO Documentation:	 + ( ) - ( )
2. Staff Functions a. Organization chart ☒YES ☐NO b. Position descriptions - all staff ☒YES ☐NO c. Hospital staff and others participating in patient staffing. ☒YES ☐NO Documentation:	 + ( ) - ( )
(b) and (c) Clinical Records 1. Complete evaluation within 48 hours after admission (including psychiatric examination, family and social history, psychological exam if indicated). ☒YES ☐NO 2. Treatment plan for each patient. ☒YES ☐NO 3. Periodic treatment plan review by staff professionals. ☒YES ☐NO 4. Patient involved in writing treatment plan. ☒YES ☐NO 5. Weekly progress notes by staff professionals. ☒YES ☐NO Documentation:	 + ( ) - ( )
(e) If the program includes a group therapy program - provide written description. ☒YES ☐NO Documentation:	 + ( ) - ( )
(f) Written description of activity therapy program consistent with inpatient treatment requirements. ☒YES ☐NO Documentation:	 + ( ) - ( )

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
HFS 61.71/61.79.sav (date) (12-91) (Updated 1-06)

STATE OF WISCONSIN

(j) If your program is unified board operated or contracted, a written plan for integration and coordination with other services - including: 1. Clinical record transfer policy. ☒YES ☐NO 2. Alternate care resources. ☒YES ☐NO 3. Vocational rehabilitation and sheltered workshop resources. ☒YES ☐NO 4. Resource directory. ☒YES ☐NO Documentation:	 + ( ) - ( )
HFS 61.72, 61.78, 61.79 - Staff Development	
1. Written policy that ensures that all staff meet appropriate mental health education, experience, and aptitude requirements. ☒YES ☐NO 2. Staff development program. ☒YES ☐NO 3. 48 hours per year of in-service training for staff serving children and adolescents. ☐YES ☒NO Documentation:	 + ( ) - ( )
COMMENTS:	

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Quality Assurance
HFS 61.71/61.79.sav (date) (12-91) (Updated 1-06)

STATE OF WISCONSIN

PART II
SURVEY REPORT
ADDITIONAL REQUIREMENTS FOR CHILD AND
ADOLESCENT INPATIENT TREATMENT PROGRAMS
HFS 61.78 - 61.79

Written policy that meets or exceeds the following staffing requirements:	FOR SURVEYOR USE ONLY
HFS 61.78(2)(a) and 61.79(1)(a) Psychiatry 1. Licensed child psychiatrist certified/eligible for certification by American Board of Psychiatry and Neurology ☒YES ☐NO or 2. Psychiatrist with at least 2 years of clinical work with children and adolescents ☒YES ☐NO 3. Minimum of 1.4 hours per patient per week ☒YES ☐NO	+ ( ) - ( )
HFS 61.78(2)(b)1 and 61.79(b)1 Nursing Service 1. .64 hour per patient per day (4.48 per week) - day and evening shifts ☒YES ☐NO 2. .32 hour per patient per day (2.24 per week) - night shift ☒YES ☐NO	+ ( ) - ( )
HFS 61.79(1)(b)2 Aides, child care workers, other paraprofessionals -for Children 1. .98 hour per patient per day (6.86 per week) - day shift ☒YES ☐NO 2. 1.28 hours per patient per day (8.96 per week) - evening shift ☒YES ☐NO 3. .64 hour per patient per day (4.48 per week) - night shift ☒YES ☐NO	+ ( ) - ( )
Aides, child care workers, other paraprofessionals - For Adolescents 1. .8 hour per patient per day (5.6 per week) - day shift. ☒YES ☐NO 2. 1.1 hours per patient per day (7.7 per week) - evening shift ☒YES ☐NO 3. .4 hour per patient per day (2.8 per week) - night shift ☒YES ☐NO	+ ( ) - ( )
HFS 61.78(2)(c) and 61.79(1)(c) Activity Therapy 1. At least one full-time activity therapist ☒YES ☐NO 2. 1.6 hours per patient per day ☒YES ☐NO 3. Structured and unstructured activities - day, evening, weekend ☒YES ☐NO	+ ( ) - ( )

HFS 61.78(2)(d) and 61.79(1)(d) Social Service 1. 1.6 hours per patient per week ☒YES ☐NO	 + ( ) - ( )
HFS 61.78(2)(e) and 61.79(1)(e) Psychological Service 1. 1 hour per patient per week ☒YES ☐NO	 + ( ) - ( )
HFS 61.78(2)(f) and 61.79(1)(f)-(h) Education and Vocational Services 1. At least one certified teacher (employed by program or by local education agency) ☒YES ☐NO 2. 4.8 hours per patient per week ☒YES ☐NO 3. 1 hour per patient per week of speech and language therapy as indicated ☐YES ☒NO 4. 1.3 hours per patient per week of individual vocational counseling and training as indicated - for adolescents over 14 years of age ☐YES ☒NO Documentation for personnel requirements: 	 + ( ) - ( )
HFS 61.72(2)(a)-(e) and 61.78(1) PROGRAM OPERATION AND CONTENT Description of child and adolescent inpatient treatment program philosophy and design, policies and procedures, including: intake, treatment services, and special education, vocational, and activity programs, including HFS 61.78 and 79. Documentation: 	
COMMENTS:	

Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Community Support Services and Case Management

> **Service Access to Independent Living (SAIL)**
> **Targeted Case Management (TCM) (outsourced?)**
> **Community Support Program (CSP) (outsourced?)**
> **Community Recovery Services (CRS)**
> **Comprehensive Community Services (CCS)**
> **Mobile Treatment Teams (MTT)**

March, 2015

Completed By: Name: Contact (phone or email)

(LEAD)	

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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Milwaukee County Behavioral Health Department
Replacement Hospital Program Study

Appendix E - Questionnaire Responses and Data
Page E-70

Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Program Description

1.1 What Community Support Services and Case Management Programs are being provided at the hospital? For each provide the program name, funding source, a brief description of the current program, and a description of how the program will change in the future.

Outpatient Administration: Invcludes service chiefs and central functions plus GME. For psychology this is 4 FTE's Alicia will get back with total count.

Service Access to Independent Living (SAIL) aka Community Access to Recovery Services (CARS): needs assessments and referrals Assessments takes place at 5 different locations in the community. ?FTE's Get AMY and Jennifer to talk with me. What we really need to know is how many FTE's are in the building. They don't need to be located at the hospital in the future.

Targeted Case Management (TCM): Outsourced to community providers? Same on site staff as SAIL/CARS.

Community Support Program (CSP): Outsourced to community providers? Same on site staff as SAIL/CARS.

Community Recovery Services (CRS): Psychosocial services such as housing, employment (counseling?) and peer support via assessment, development of individualized plan of car and plan implementation support. Same on site staff as SAIL/CARS.

Comprehensive Community Services (CCS): Early intervention and treatment for clients who are stepping down from CSP. Includes services like medication management, psychotherapy, employment training and life skills training. Same on site staff as SAIL/CARS.

Community Linkages and Stabilization Program (CLASP): Supports recovery and independence through post-hospitalization extended support and treatment using Certified Peer Specialists overseen by a clinical coordinator.

AODA: Same on site staff as SAIL/CARS.

Mobile Treatment Teams (MTT): Mobile clinical intervention team resulting in reduced ED/ER admissions. Generally referrals are made by public safety first resonders in the field. This group also covers crisis hotline.   Peer support warm line is a one person office that should be colocated.

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Milwaukee County Behavioral Health Department
Replacement Hospital Program Study

Appendix E - Questionnaire Responses and Data
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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

2. For each program listed above, beyond offices what spaces are needed to support the future program? To what extent can any of these spaces be shared with other programs.

3. Please list the titles of **current** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Program/Department (overwrite Actual Name)						
Program/Department (overwrite Actual Name)						
Program/Department (overwrite Actual Name)						
Program/Department (overwrite Actual Name)						

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Milwaukee County Behavioral Health Department
Replacement Hospital Program Study

Appendix E - Questionnaire Responses and Data
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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Program/Department (overwrite Actual Name)						
Program/Department (overwrite Actual Name)						
Program/Department (overwrite Actual Name)						
Program/Department (overwrite Actual Name)						
Program/Department (overwrite Actual Name)						
Other Shared Services						

4. Adjacency Requirements

Describe *ideal critical internal adjacency relationships* within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Please note any differing opinions that still exist at the conclusion of your discussions.

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

7. Adjacency Requirements (continued)

Describe critical *ideal future external adjacency relationships* that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR	REASON INDICATOR
1 - Directly next to	A – Resident movement
2 - Same floor	B - Staff movement
3 - Doesn't matter	C - Materials movement

Department	Closeness	Reason	Contacts/Day

Please note any differing opinions that still exist at the conclusion of your discussions.

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

5. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

6. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Outpatient and Ambulatory Services
Drop-in Access Clinic
Day Treatment
Crisis Resource Center (off-site walk in centers)

March, 2015

Completed By: Name: Contact (phone or email)

(LEAD)	

Please return this questionnaire by Friday, April 10, 2015

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to Mr. Francis Pitts, pittsf@aplususa.com

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

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INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

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Program Description

1.1 What Outpatient and Ambulatory Services will be provided at the new hospital? For each
provide the program name, typical clinical interactions, funding source, a brief description of
the current program, and a description of how the program will change in the future.

Drop In Access Clinic: One at hospital and one contracted on the southside Whether it belongs
here really depends upon geographic location of the hospital and the outpatient centroid.
Utilization has decreased because of the Affordable Care Act. If provided at centroid would
contribute to reduced utilization but would still need a small team here. 4 FTE's at present.

Hundreds of vists a few years ago. Up to 20 folksa dayt a few years ago. Now about 2. (They'll
send data.)

Might consider collocating with SAILS in terms of back end services.

Day Treatment: 23 patients served by two teams. 13 per team. Three to 5 month treatment
regime per patient. 15 FTE's. Four hours per day four days a week. Majority of time is spent in
Group with consult being used while in crisis. Each team has two group rooms, the service needs
an OT room and a music therapy room and a meds room. They also need access to an exam
room. 9-4:30 M, Tu, Th, and Fr. Wed is used for consultation meetings, training and intakes.
Both groups start at 10:00 AM and end at 3:00 PM with lunch at noon. Patients show up early
and linger.   They get patients from everywhere but about 40% form inpatient beds in the
network. Probably best to be located at the hospital. CCS could increase utilization and possibly
acuity. Currently have no wait list. Have only had a formal wait list two times in the past 5
years. Convenient but not essential to be located next to SAIL.

Crisis Resource Center (off-site walk in centers operated by contract providers)

1.2 What are your current and projected annual service volumes for each program to be housed at
the hospital? If measured in individual clients, please also describe the average number of
annual visits per patient, the duration of a typical visit and the nature of the clinical
interactions.

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2. For each program listed above, beyond offices what spaces are needed to support the future program?

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3. Please list the titles of **current** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Program/Depart ment (overwrite Actual Name)						
Program/Depart ment (overwrite Actual Name)						
Program/Depart ment (overwrite Actual Name)						
Program/Depart ment (overwrite Actual Name)						
Program/Depart ment (overwrite Actual Name)						
Program/Depart						

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
ment (overwrite Actual Name)						
Program/Depart ment (overwrite Actual Name)						
Program/Depart ment (overwrite Actual Name)						
Program/Depart ment (overwrite Actual Name)						
Other Shared Services						

4. Adjacency Requirements

   Describe **ideal critical internal adjacency relationships** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason

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7. Adjacency Requirements (continued)

Describe critical **ideal future external adjacency relationships** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day

Please note any differing opinions that still exist at the conclusion of your discussions.

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Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

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5. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Outpatient and Ambulatory Services

March, 2015

Completed By: Name: Contact (phone or email)

(LEAD)	
Bruce Kamradt, Director	257-7521 or 257-7639
	Bruce.kamradt@milwaukeecountywi.gov

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Program Description

1.1 What Outpatient and Ambulatory Services will be provided at the new hospital? For each provide the program name, typical clinical interactions, funding source, a brief description of the current program, and a description of how the program will change in the future.

Wraparound Milwaukee has a medication clinic that sees over 800 children a year. Youth come in, meet with the nurse for general vitals and history taking, and then meet with the physician.

These youth are funded with the same pooled funding source as all Wraparound youth – Medicaid, Juvenile Delinquency and the Bureau of Milwaukee Child Welfare.

We anticipate the clinic attendance expanding approximately 10% a year.

We also run a Health Women's Clinic. Currently, it is brand new clinic and is open only 1 day a month. However, the intention is to expand this during the coming year. At this clinic, there will be a full medical evaluation performed by the physician.

1.2 What are your current and projected annual service volumes for each program to be housed at the hospital? If measured in individual clients, please also describe the average number of annual visits per patient, the duration of a typical visit and the nature of the clinical interactions.

On average, our med clinic youth are seen every other month (6 times yearly)

Our Healthy Women's Clinic is new, but we anticipate they will be seen quarterly (4 times per year). These visits are a full medical exam.

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2. For each program listed above, beyond offices what spaces are needed to support the future program?

MED CLINIC

We need separate offices for all four of our current physicians and for our two nurses. We also need a 'screening' room where the nurses can take vitals, weigh the youth, etc.

When families come to the clinic, they are often joined by their care coordinator and bring other family members. We need a waiting room to accommodate at least 25 people. Ideally, two separate rooms – one for older youth and one for young babies and toddlers – would be idea.

HEALTHY WOMEN'S CLINIC

Exam room with a sink and separate bathroom.

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lease list the titles of *current* staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Administration	9	9		3-4	X	
Finance	5	5				
QA/QI	3	3				
Provider Network	3	3		2		
Med Clinic	5 (4 - 0.5)	9		20	X	X
Consultant	15	15		2		
Transitional Services	1	4				
Court Services	3	3				

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
MUTT	8	20			X	X
FISS	1	8		6	X	X
Other Shared Services						

3. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason
Pharmacy / Dynacare Lab	Med Clinic	Medication dispensing / lab work

7. Adjacency Requirements (continued)

Describe critical **ideal future external adjacency relationships** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor

REASON INDICATOR
A – Resident movement
B - Staff movement

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3 - Doesn't matter   C - Materials movement

Department	Closeness	Reason	Contacts/Day

Please note any differing opinions that still exist at the conclusion of your discussions.

Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

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4. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

Ideally, we would like our medication clinic and Healthy Women's Clinic to be co-lated with Wraparound Milwaukee offices. This will reinforce our movement to a home health model, maintaining closer ties to physical health providers.

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Community Support Services and Case Management

March, 2015

Completed By: Name: Contact (phone or email)

Name	Contact (phone or email)
(LEAD)	
Bruce Kamradt, Director	257-7531 or 257-7639
	Bruce.kamradt@milwaukeecountywi.gov

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6.   The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7.   Please state when information is not available or estimates are provided as answers to any questions.

8.   If any question does not relate to your department, please indicate "Not Applicable".

9.   It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Program Description

1.1 What Community Support Services and Case Management Programs are being provided at the hospital? For each provide the program name, funding source, a brief description of the current program, and a description of how the program will change in the future.

Wraparound Milwaukee is a specialized managed care entity and HMO serving 2500 children and families with serious emotional and mental health needs.

Program Names: Wraparound Milwaukee / Mobile Urgent Treatment Team (MUTT) / Family Intervention and Support Services (FISS)

We are funded by Medicaid, Child Welfare and Juvenile Justice.

In terms of future growth, we anticipate a growth of 10% per year each year.

We also operate a Community Resource Center and a Transitional Care Program for young adults 17-22 at Owen's Place on Fond du Lac Avenue.

2. For each program listed above, beyond offices what spaces are needed to support the future program? To what extent can any of these spaces be shared with other programs.

We need 2 conference / training rooms with a capacity of 75 people each; 1 conference / training room with a capacity of 100 / we need 3 other conference rooms with a capacity of 30. We need a computer training room with 8 stations. We need 2-3 copy rooms. We also need a glassed-in reception area with a waiting room for visitors with a capacity to seat 20.

The population we serve are generally youth under age 18. We often have very young children accompanying family members to sessions, so we need a child-specific waiting and clinic areas.

Community Location – we have offices for Mobile Trauma Team at new Sojournor Justice Center on Walnut St.

3. Please list the titles of *current* staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

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Milwaukee Board of Behavioral Health
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Questionnaire
Community Support Services and
Case Management

March, 2015

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Administration	9	9		3-4	X	
Finance	5	5				
QA/QI	3	3				
Provider Network	3	3		2		
Med Clinic	5 (4 - 0.5)	9		20	X	X
Consultant	15	15		2		
Transitional Services	1	4				
Court Services	3	3				
MUTT	8	20			X	X
FISS	1	8		6	X	X
Other Shared						

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Services						

4. Adjacency Requirements

Describe ***ideal critical internal adjacency relationships*** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason
Mobile Urgent Treatment Team	Psychiatric Crisis Service (PCS)	Staff in MUTT serve as gatekeepers for PCS for children
General staff including MUTT	CAIS (Child Adolescent Inpatient Unit)	Staff in MUTT visit youth while they're on the unit; our staff physicians will also make visits
Adult Community Services	Transitional Services for young adults and first episode psychosis	Some shared clients and to facilitate transition of youth and young adults to CCSI, Targeted Case Management, and CSP.

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Please note any differing opinions that still exist at the conclusion of your discussions.

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

7. Adjacency Requirements (continued)

Describe critical *ideal future external adjacency relationships* that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day
Children's Court	w/in 1 mile	B	100 on average
9501 Building (old CATC)	w/in 1 mile	B	10 times a day
Bureau of Child Welfare	w/in 1 – 5 miles	B	10-20 times a day
Owen's Place	w/in 1 -5 miles	A, B	15-20

Please note any differing opinions that still exist at the conclusion of your discussions.

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

5. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
Two large conference rooms	All of BHD and any outside agencies that want to reserve it	Availability on a first-come basis.
Our child psychiatrists	CAIS	They work half-time in each program

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Milwaukee Board of Behavioral Health
Hospital Programming Project

Questionnaire
Community Support Services and
Case Management

March, 2015

6. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

There have been discussions of the creation of the division of Children's Mental Health and Safety, which would include Wraparound Milwaukee and Delinquency and Court Services. There are also some discussions of the County assuming Child Welfare again.

We are also currently leasing office space to some providers, including our educational advocates and Willowglen care coordination staff.

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Child and Adolescent Wrap-Around
A managed care entity for kids and families
Serve 1,700 clients
11,00 enrolled on any given day.
Likely to grow. Probably 100 per year.

Current;y housed is
- Overall: 38 FTE country and 52 contractors in FIS and MUT
- About 20 admin FTE Probably should be co-located with direct care patient services ar centroid
- Pregnancy protocol clinic 1x per month in the evening. Can use medical clinic.
- medical clinic with 800 enrolled children: primary care and medication management 1 FT and 3 PT psychiatrists, 2 nurses, exm interview and office space. 30-40 families per day, 120 per week, volume follows psychiatrists work schedule. Locate at demographic services centroid,
- training of 150 case managers currently use room 416. New case manager training, every couple of months 25-75 per room, monthly cae manager meetings. also need a room for 150-160 person rooms. (they'll send Probably should be co-located with direct care patient services ar centroid
- Children's mobile treatment team (MUT): 25 people on a 24 hour basis. In building on first and second shift. 1st shift has the most staff: 6-7 staff. Need workstations. Manning phones, taking phone calls. workstations are shared across shifts. working as teams boyh here and away Locate at hospital near PCS
- Computer lab: run their own managed care software system. 1 IT coordinator, 2 FT contract developers, in future this will go on county system, Doesn't need to be in the new building.
- High risk reviews a couple times a week done by outside care coordinators on two afternoons a week. Use a meeting room. Up to seven folks max Colocate with admin offices.
- Family Intervention and Support: contract with Child Welfare, currently occupy space next to the mobile team. Court diversion. 400-500 1.5-2 hour interviews per year. Families come in for meetings/services: assessments and case management. 7 FTE's. Locate at demographic services centroid,

- Locate at demographic services centroid,

Locate at hospital near PCS

Assume that registration and IT become centralized.

Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Therapy/Activity

Please cross-off therapies not provided and add additions as needed:
Rehabilitation Leadership
Physical Therapy (contracted as needed)
Occupational Therapy
Vocational Services
Recreation Therapy/Gym/etc.
Music Therapy
Speech and Hearing
Library/Patient Education/Technology Center
Patient Clothing
Bank/Patient Property
Barber Shop/Beauty Shop
Chapel
Canteen/Gift Shop
Transportation/Community Integration
Outdoor Functions

March 24, 2015

Completed By: Name: Contact (phone or email)

Name	Contact (phone or email)
(LEAD) Alicia Modjeska	
Jennifer Bergersen	
Ray Gurney	
Mary Stryck	

Please return this questionnaire by Friday, April 10, 2015

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to Mr. Francis Pitts, pittsf@aplususa.com

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

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architecture+   3

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6.   The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7.   Please state when information is not available or estimates are provided as answers to any questions.

8.   If any question does not relate to your department, please indicate "Not Applicable".

9.   It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Program/Service Description:

1.1   Please provide a brief narrative that summarizes the current scope/operations for each of the programs/services listed below. From the big picture perspective, what do you do and what are your treatment goals (including contact hours per week)?

Rehabilitation Leadership
Rehab services, occupational and music therapy. OT, evaluate for functionality PT is contracted out and provided by a vendor. Speech is also contracted out. Some specialized OT services are offered by column rehab.

Vendor does provide therapies for the acute unit. Would most likely continue to outsource PT and provide the PT at the bedside or on the units. The PT volume is so low in the acute units it is not cost effective to build a PT department.

Physical Therapy
xxxx

Occupational Therapy

Recreation Therapy/Gym/etc
There are no RT's currently used in the facility.

Music Therapy/and OT (together)
Both therapies provide assessments in addition the OT's do functional assessments which lead to referrals to PT/Speech. CALS is used an the evaluation model and therefore would be helpful to have a phone.
Falls assessment.
Music and OT provide groups and they large rooms for music groups. Individual contacts occur on the units.
The sensory rooms are used on the unit.
Assessments are generally done on the unit. Equipment and home like/apartment areas needed to conduct full OT assessments and teaching. Laundry facilities would be helpful as well.
OT participate in recovery teams / staffing/morning report
A documentation area on the units is desirable to use the EMR- there is a lot of information sharing between staff when the documentation occurs on the units.
There is a desire to do some group sessions outside but require shaded areas due to photo sensitivity.
A room with high ceilings is needed to be used in the winter time to use balls, and gardening areas.

Library/Patient Education/Technology Centre
Very desirable to have some technology available for the patients, area with resources would also be used but not a full library.

Francis Pitts 5/20/15 11:11 AM
Comment [1]: Central multi-purpose room with instrument storage or cart-based? Yes

Francis Pitts 5/20/15 11:12 AM
Comment [2]: ADL of use unit apartments? Yes, ADL Kitchen

Francis Pitts 5/20/15 11:14 AM
Comment [3]: How many w.s./offices per unit? Have 8 rehab staff plus 4 OT. Staff. House centrally with hotelling at IPU's. (Would consume 1 hotelling slot per IPUY)

Francis Pitts 5/20/15 6:15 AM
Comment [4]:

Francis Pitts 5/20/15 11:15 AM
Comment [5]: Gym and Movement

Francis Pitts 5/20/15 11:17 AM
Comment [6]: About 6 ft of stack plus 4 computers.

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5

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Bank
NA

Chapel
A spirituality area, with possibility of a chapel.

COMING VIA EMAIL

Canteen/Gift Shop
Not needed

Transportation/Community Integration
Currently all outsourced

Outdoor Functions
Required to have some outdoor functions and opportunity to get fresh air in a safe/secured space. Containing a walking area and sitting space.

Areas need to be separate adult from kids

Shaded s pace for photosensitivity and general shade.

| Francis Pitts 5/20/15 6:18 AM |
| **Comment [7]:** |

Other?

1.2   Please provide your thoughts on the changes that will occur to the nature of the program and its services in moving to a new facility (this could include an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, etc.)

Rehabilitation Leadership
xxxx

Physical Therapy
xxxx

Occupational Therapy
A treatment Mall concept- an area dedicated for group treatments. A central area where music therapy could be offered, as well as OT. These Malls should be adjacent to the units. This concept would avoid having to bring the equipment to and from the units on carts.

| Francis Pitts 5/20/15 11:17 AM |
| **Comment [8]:** As programmed. |

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Recreation Therapy/Gym/etc
Would increase the amount of physical activity for the patients.

Music Therapy
xxxx

Library/Patient Education/Technology Centre
xxxx

Bank
xxxx

Chapel
A spirituality room for family. A dedicated spiritual space for patients. These are two separate areas, one is public and one in the treatment space.

Canteen/Gift Shop
NA

Transportation/Community Integration
NA – see below.

Outdoor Functions
Would also like an outdoor meditation garden, and Monarch Waystation licensed in the same area with sitting. Sitting needs to be closer to facilitate discussion and conversations.

Other?

2. List the main program elements (spaces or functions) of each area currently.   This includes key features of your program. Please add comments focusing also on elements that relate to shortcomings of you area in relation to your concept of the ideal patient care, service delivery and/or staff environment.

   Rehabilitation Leadership

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Physical Therapy

Not enough room or storage. It is important to have 2 doors in a group room. Need group rooms to have doors with glass window to facilitate for patient checks.

Sound proofing is needed in the group rooms and large areas like nursing station.

Francis Pitts 5/20/15 6:19 AM
Comment [11]:

Occupational Therapy

Need private interview spaces.

Sensory rooms should be closer to the nurse's station so the staff feels isolated

Need visitor area. There is nowhere for families and patients to meet

Need dedicated area for staff meetings, break rooms, eating area

Not enough supply rooms in the units for OT equipment / no sink in areas.

There are no clocks in patient rooms- difficult for patients to keep schedules and stay oriented to time/day.

The current furniture is totally uncomfortable. Need furniture that can be kept clean but also be comfortable.

Francis Pitts 5/20/15 6:20 AM
Comment [12]: Discuss all

Recreation Therapy/Gym/etc

Music Therapy

xxxx

Library/Patient Education/Technology Centre

xxxx

Bank

xxxx

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Chapel
xxxx

Canteen/Gift Shop
xxxx

Transportation/Community Integration
xxxx

Outdoor Functions
xxxx

Other?
xxxx

3. Please describe the current internal operations and functions of each area that support the activities and functions identified above. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are currently located in several places across the Facility fragmenting workflow, supervision, etc.

Rehabilitation Leadership
xxxx

Physical Therapy
xxxx

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9

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Occupational Therapy
xxxx

Recreation Therapy/Gym/etc
xxxx

Music Therapy
xxxx

Library/Patient Education/Technology Centre
xxxx

Bank
xxxx

Chapel
xxxx

Canteen/Gift Shop
xxxx

Transportation/Community Integration
xxxx

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Outdoor Functions
xxxx

Other?
xxxx

4. Please indicate if there are any operational changes that would improve the efficiency of each area and in particular any physical features that could make your area more efficient.

Rehabilitation Leadership
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

Physical Therapy
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions
xxxx

Occupational Therapy
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions
xxxx

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Recreation Therapy/Gym/etc
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Music Therapy
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Library/Patient Education/Technology Centre
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Bank
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

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Chapel
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Canteen/Gift Shop
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Transportation/Community Integration
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Outdoor Functions
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Other?

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13

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xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

6. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Rehabilitation Leadership
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Physical Therapy
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Occupational Therapy
xxxx

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Please note any differing opinions that still exist at the conclusion of your discussions

xxxx

Recreation Therapy/Gym/etc
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

Music Therapy
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

Library/Patient Education/Technology Centre
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

Bank
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

Chapel
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

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xxx

Canteen/Gift Shop
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

Transportation/Community Integration
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

Outdoor Functions
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

Other?
xxx

Please note any differing opinions that still exist at the conclusion of your discussions

xxx

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5. Please list the titles of **current** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. We will discuss future staffing during our face to face meeting. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Rehabilitation Leadership						
Physical Therapy						
Occ'l Therapy						
Rec Therapy/ Gym/etc						
Music Therapy						

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Library/Patient Ed'n/ Technol'y Ctr						
Bank						
Chapel						
Canteen/Gift Shop						
Transportation/ Community Integration						
Other						

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6. Adjacency Requirements

Describe *ideal critical internal adjacency relationships* within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason

Please note any differing opinions that still exist at the conclusion of your discussions.

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7. Adjacency Requirements (continued)

Describe critical **ideal future external adjacency relationships** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. Again, please think about it from your understanding of the future patient profile and a new facility/environment.

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day

Please note any differing opinions that still exist at the conclusion of your discussions.

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7. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

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8. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?
   xxx

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Therapy/Activity

Please cross-off therapies not provided and add additions as needed:
~~Rehabilitation Leadership~~
~~Physical Therapy~~ *(contracted as needed)*
~~Occupational Therapy~~
~~Vocational Services~~
~~Recreation Therapy/Gym/etc.~~
~~Music Therapy~~
~~Speech and Hearing~~
~~Library/Patient Education/Technology Center~~
~~Patient Clothing~~
~~Bank/Patient Property~~
~~Barber Shop/Beauty Shop~~
(Chapel) Spirituality
~~Canteen/Gift Shop~~
~~Transportation/Community Integration~~
~~Outdoor Functions~~

March 24, 2015

Completed By: Name: Contact (phone or email)

Rev. Ray Gurney	414 257-7221

Please return this questionnaire by Friday, April 10, 2015 to
Mr. Francis Pitts, pittsf@aplususa.com

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PURPOSE OF THIS QUESTIONNAIRE

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- To communicate information about the Hospital's current and future programs and services to the Planning Team

- To serve as a tool for the Planning Team in evaluating demands and needs of departments ·

    To assist in the development of a database useful in planning activities.

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Program/Service Description:

1.1   Please provide a brief narrative that summarizes the current scope/operations for each of the programs/services listed below. From the big picture perspective, what do you do and what are your treatment goals (including contact hours per week)?

Rehabilitation Leadership xxxx

Physical Therapy xxxx

Occupational Therapy
xxxx

Recreation Therapy/Gym/etc xxxx

Music Therapy xxxx

Library/Patient Education/Technology Centre xxxx

Bank xxxx

(Chapel) Spirituality - To facilitate the availability of a broad spectrum of healing practices through the incorporation of spiritual beliefs and knowledge (and secular alternatives) in the Behavioral Health Division (BHD) and its various treatment settings and the general environment of BHD in a way that promotes spiritual and emotional well-being throughout the delivery of services and the recovery process with emphasis on the strengths of every individual in order to experience compassionate care to the whole person while respecting each individual's beliefs and needs.

Canteen/Gift Shop
xxxx

Transportation/Community Integration xxxx

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Outdoor Functions
xxxx

Other?
xxxx

1.2   Please provide your thoughts on the changes that will occur to the nature of the program and
       its services in moving to a new facility (this could include an overall change to the acuity or
       treatment needs of the patients, new opportunities in treatment programming that will be
       possible in a new facility, etc.)

Rehabilitation Leadership xxxx

Physical Therapy xxxx

Occupational Therapy
xxxx

Recreation Therapy/Gym/etc xxxx

Music Therapy xxxx

Library/Patient Education/Technology Centre xxxx

Bank xxxx

(Chapel) Spirituality – Visitors, individual staff, and special event participants will
   use the chapel proper (space for approx. 30).   Patients will need a room for on-unit
   groups and worship services (this can be a shared room with OT, MT, etc.) A
   meditation garden needs to be established to replace the current one. This is a
   garden that is a Registered Monarch Waystation with the Monarch Watch project at
   the University of Kansas. A built in display case is needed to replace the case
   currently on Main Street. This is used for a variety of nature displays, including
   raising monarchy butterflies from eggs each summer. A shared office for the staff
   Spirituality Integration Coordinator and visiting chaplains is also needed. This
   should include storage areas for Bibles, Qurans, vestments, supplies etc.

Francis Pitts 5/20/15 10:34 AM
Comment [1]: One worksurface for the
FT chaplain and one shared by three
visiting chaplains

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Canteen/Gift Shop
xxxx

Transportation/Community Integration xxxx

Outdoor Functions
xxxx

Other?
xxxx

2. List the main program elements (spaces or functions) of each area currently.   This includes key
   features of your program. Please add comments focusing also on elements that relate to
   shortcomings of you area in relation to your concept of the ideal patient care, service delivery
   and/or staff environment.

   Rehabilitation Leadership xxxx

   Physical Therapy xxxx

   Occupational Therapy
   xxxx

   Recreation Therapy/Gym/etc xxxx

   Music Therapy xxxx

   Library/Patient Education/Technology Centre xxxx

architecture+   6

Bank xxxx

(Chapel) Spirituality - Worship services, memorial services, religious holiday services, employee gatherings, etc. in the chapel proper. Groups and individual spiritual counseling on the patient units. More patient and staff contact time is spent on the units as compared to the chapel. Visitors and staff use the chapel as a drop in peaceful location for meditation and prayer.

> Francis Pitts 5/20/15 10:36 AM
>
> ***Comment [2]:*** Reserve for meditation. Don't use for other purposes other than relaxation therapy and occasional scheduled events like memorial services.

Canteen/Gift Shop
xxxx

Transportation/Community Integration xxxx

Outdoor Functions
xxxx

Other?
xxxx

3. Please describe the current internal operations and functions of each area that support the activities and functions identified above. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are currently located in several places across the Facility fragmenting workflow, supervision, etc.

Rehabilitation Leadership xxxx

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Physical Therapy xxxx

Occupational Therapy
xxxx

Recreation Therapy/Gym/etc xxxx

Music Therapy xxxx

Library/Patient Education/Technology Centre xxxx

Bank xxxx

(Chapel) Spirituality - The chapel proper is now used for all of the purposes
mentioned above. There is a lack of storage space in the office. Availability of rooms on
the patient units for spirituality groups and individual spiritual care is very limited. The
Monarch Waystation is located close to an entrance and has its own supply of water.
This is an ideal arrangement.

Canteen/Gift Shop
xxxx
Transportation/Community Integration
xxxx

Outdoor Functions
xxxx

architecture+   8

> **Francis Pitts 5/20/15 10:39 AM**
>
> *Comment [3]:* Outdoor past Look
> acriss from Barber Shop for the
> display case. (They hatch eggs,
> grow catepillars and watch them
> emerge within the display case)
> Outside is a dedicated butterfly
> garden registered with the program.
> Need water at outside garden for
> irrigation.

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Other?
xxxx

4. Please indicate if there are any operational changes that would improve the efficiency of each
   area and in particular any physical features that could make your area more efficient.

Rehabilitation Leadership xxxx

Please note any differing opinions that still exist at the conclusion of your discussions

Physical Therapy xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Occupational Therapy
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Recreation Therapy/Gym/etc xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

architecture+   9

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Music Therapy xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Library/Patient Education/Technology Centre xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Bank xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

(Chapel) Spirituality - Storage area adjacent or within office and office connected to chapel through hall door as well as direct entrance into chapel. Storage area for material used in Monarch Waystation and butterfly rearing.

> Francis Pitts 5/20/15 10:39 AM
>
> **Comment [4]:** About 2 cubic feet of storage space. Can be a part of the Chaplain's storage space.

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Canteen/Gift Shop
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

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10

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Transportation/Community Integration xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Outdoor Functions
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Other?
 xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

6. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Rehabilitation Leadership xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

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Physical Therapy xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Occupational Therapy
xxxx

Please note any differing opinions that still exist at the conclusion of your discussions xxxx

Recreation Therapy/Gym/etc xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

Music Therapy xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

Library/Patient Education/Technology Centre xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

Bank xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

(Chapel) Spirituality – Trend in chapel architecture is toward multi-religious use as well as secular forms of spirituality in one space. There are several design approaches

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12

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that address these issues, especially in a government building (such as the VA). In addition, more emphasis is being placed on adequate meditation spaces that can function as a "chapel" as well. Meditation rooms on patient units will be needed in the future as this is major evidenced based intervention that is becoming wide spread (can also be a serenity room). Note: The current Spirituality Integration Coordinator is presently pursuing certification as a Mediation Instructor.

Please note any differing opinions that still exist at the conclusion of your discussions xxx

Canteen/Gift Shop
xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

Transportation/Community Integration xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

Outdoor Functions
xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

Other?
xxx

Please note any differing opinions that still exist at the conclusion of your discussions xxx

5. Please list the titles of ***current*** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. We will discuss future staffing during our face to face meeting. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

architecture+   13

> **Francis Pitts 5/20/15 10:43 AM**
> **Comment [5]:** OK with comfort, quiet and multi-purpose as on-unit adjunctive space. Chapel is used for staff and family meditation. Most patients won't be accessing the chapel for meditation, but will be using rooms on unit.

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Rehabilitation Leadership						
Physical Therapy						
Occ'l Therapy						
Rec Therapy/ Gym/etc						
Music Therapy						

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Library/Patient Ed'n/ Technol'y Ctr						
Bank						
(Chapel) Spritualty	.75	1 plus 3 visiting chaplains	1 shared desk and computer		Dedicated	
Canteen/Gift Shop						
Transportation/ Community Integration						
Other						

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15

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6. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason
Close to a printer, copier		

Please note any differing opinions that still exist at the conclusion of your discussions.

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7. Adjacency Requirements (continued)

Describe critical *ideal future external adjacency relationships* that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. Again, please think about it from your understanding of the future patient profile and a new facility/environment.

<table>
<tr><td>CLOSENESS INDICATOR</td><td>REASON INDICATOR</td></tr>
<tr><td>1 - Directly next to</td><td>A – Resident movement</td></tr>
<tr><td>2 - Same floor</td><td>B - Staff movement</td></tr>
<tr><td>3 - Doesn't matter</td><td>C - Materials movement</td></tr>
</table>

Department	Closeness	Reason	Contacts/Day

Please note any differing opinions that still exist at the conclusion of your discussions.

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7. Please list materials, space, personnel or other resources that you currently share with any
    other department(s). Please indicate which department(s) and describe the nature of the
    sharing.

What do you Share	Share with Whom	Nature of Sharing

8. This there any other information or data that you feel the programming/planning team
    should be aware of that has not been requested by this questionnaire? xxx

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19

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Clinical Ancillaries
    Laboratory Processing
    Pharmacy

March, 2015

Completed By: Name: Contact (phone or email)

Name	Contact (phone or email)
(LEAD)	
Jody Fenelon	
Alicia Modjeska	

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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architecture+

PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

architecture+　　　　　　　　　　　　　　　　　　　　　　　1

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

architecture+   2

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Program/Service Description:

1.1 Please provide a brief narrative that summarizes the current scope/operations for each of the programs/services listed below

Laboratory – outsourced.

Francis Pitts 5/20/15 8:08 AM
Comment [1]:

Pharmacy Services
The pharmacy provides pharmaceutical care services to the inpatients of the facility and patients serviced through PCS (Psychiatric Crisis Services). The department supports physicians, nurses, and other care givers by providing clinical pharmacy services, drug information, and clinical consultations. In addition, the pharmacy dispenses prescriptions to the outpatients serviced by BHD programs if no financial resources are available to patients in community.

Francis Pitts 5/20/15 8:08 AM
Comment [2]: Volumes?

Shared Support (e.g. reception, waiting, clean and soiled utility rooms, etc.)

1.2 Please provide your thoughts on the changes that will occur to the nature of the program and its services in moving to a new facility with fewer total beds (this could be the result of an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, etc.)

Laboratory

Pharmacy Services
The overall provision of pharmacy services will not change. A decrease in the number of patients may allow pharmacists to provide other services such as involvement in patient care teams or patient medication counselling.

Shared Support (e.g. reception, waiting, clean and soiled utility rooms, etc.)

2. List the main program elements (spaces or functions) currently of each area. This includes key features of your program. Please focus also on elements that relate to shortcomings of you area in relation to you concept of the ideal patient care, service delivery and/or staff environment.

Laboratory

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Pharmacy Services
Functional Areas Include:

Area to receive, check in, and unpack drug orders from the drug wholesaler.

Computer workstation for ordering drugs from the drug wholesaler.

Drug picking area for Pyxis refills.

Space to process mail order prescriptions (Outpatients).

Bulk storage area and shelving for medications.

Floor space for delivery carts.

Outpatient dispensing area for outpatient prescription medications.

Medication repackaging area with computer access.

Narcotic storage area. (Pyxis CII Safe)

Pyxis 4000 counsel/workstation.

Storage for expired/unusable medications.

Workstation with computer for outpatient dispensing (QS1).

Workstations including computer for pharmacist.

Workstations including computer for technician.

Cubicle work area for clinical pharmacist.

Private office for pharmacy director.

Shared Support (e.g. reception, waiting, clean and soiled utility rooms, etc.)

| Francis Pitts 5/20/15 8:09 AM |
| **Comment [3]:** |

3. Please describe the current internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

   Clinics
Laboratory

Pharmacy Services

Problem area is lack of appropriate, confidential space to provide patient medication counseling for outpatients who pick up prescriptions.

| Francis Pitts 5/20/15 8:09 AM |
| **Comment [4]:** |

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Shared Support (e.g. reception, waiting, clean and soiled utility rooms, etc.)

4. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

    Laboratory

    Pharmacy Services
    Video monitor on pharmacy door to monitor who is requesting access to the pharmacy. Capability to "buzz in" or unlock pharmacy door from key pad on work station rather than walking to the door.

    Shared Support (e.g. reception, waiting, clean and soiled utility rooms, etc.)

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5. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Laboratory

Pharmacy Services

Semi private office space or cubicle to accommodate pharmacy students. Future programming includes developing a pharmacy student rotation with Wisconsin pharmacy schools.

Shared Support (e.g. reception, waiting, clean and soiled utility rooms, etc.)

> Francis Pitts 5/20/15 8:09 AM
> **Comment [5]:**

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6. Please list the titles of **current** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Laboratory						
Pharmacy						
Director	1	1	Office	2 visitors plus director	Room for small conference table	
Pharmacist	3	3	workstation	1 visitor		
Technician	3	3	workstation			

Francis Pitts 5/20/15 8:10 AM
Comment [6]:

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7. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason
Workstations should be in line of sight of each other		Workflow management, workflow management, supervision
Outpatient prescription area visible to rest of department		Staff can readily identify how many patients are waiting service and if additional help in the area is needed.

Please note any differing opinions that still exist at the conclusion of your discussions.

architecture+

8

7. Adjacency Requirements (continued)

Describe critical **ideal future external adjacency relationships** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day
Receiving area/outside facility door	2	C. To receive drug orders from drug wholesaler	1/day
Non visitor/patient elevator	2	C. Deliver medications to patient care area	Multiple contacts throughout the day
Psychiatric crisis service	1	A. Dispensing outpatient prescriptions.	Multiple contacts throughout the day.
Waste/trash disposal	2	Disposal of bulk shipping boxes	1/day

Please note any differing opinions that still exist at the conclusion of your discussions.

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8. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
NA		

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9. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Information Technology & Integration

Information Services
Medical Records
Quality Assurance, Incident Reporting
Staff Development
Switchboard/Communications
Education & Conferencing
Electronic/Data/Systems Integration

March, 2015

Completed By: Name: Contact (phone or email)

Name	Contact (phone or email)
EES	Steve Delgado x7335
	Sandra Del Pizzo x5101
	James Wacholz x6129
	Greg Kurzynski x4859
	Michael McAdams

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

architecture+

PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Program Description

1.1 Please provide a brief narrative that summarizes the current scope/operations for each of the programs/services listed below

Information Services

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Telephone services including internal code calls (behavioral and medical), emergency (911) calls, emergency monitoring and announcements (public address) and 2 way radios/base station. Mail services including mail receipt, sorting, distribution and outgoing (metering). Other services include copy production, laminating services, I.D. card production and parking permitting.

Education & Conferencing Services and Facilities

1.2 Please provide your thoughts on the changes that will occur to the nature of each of the services and systems as a result of moving into a new facility with fewer total beds (there could be an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, new strategies for computerization and moving more into an electronic world, etc.)

Information Services

Medical Records, including Electronic Health Record, integrated patient data/clinical information

Switchboard/Communications

Hospital: None

Hub: Communications office at each location?

Quality Assurance/Incident Review

Staff Development

architecture+   3

Francis Pitts 5/20/15 7:40 AM
Comment [1]: Discuss

Education & Conferencing Services, Facilities and Systems

Administrative and Financial Reporting Systems

Building Automation Systems

Hospital: None expected

Hubs: monitoring office?

Integrated Security Systems (patient security systems, entry/exit security systems, staff personal security/alarm systems, etc.)

Addition of Pendant Duress System (individual panic alarms), key card access, metal detection

2. List the main program elements (spaces or functions) currently of each area.   This includes key features of your program. Please focus also on elements that relate to shortcomings of you area in relation to you concept of the ideal patient care, service delivery and/or staff environment.

Information Services

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Mail and communication services are currently located in the same program space. Minor issues with noise from mail services and telephone reception. HIPAA issues??

Education and Conferencing

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3. Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

Information Services

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

The mailroom houses both the communications area and mail/office services. As noted, this leads to minor issues with sound (hearing telephone reception) and, potentially, HIPAA issues (overheard conversations?). Also, due to staffing cut backs, mailroom employees have been cross-trained to work in Operations office and storeroom. These locations are separated from the mailroom by a building and floor.

Education and Conferencing

architecture+

5

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4. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

Information Services

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Separation of mail and communication services but closer to other Operations functions

Education and Conferencing

5. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Information Services

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

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None anticipated at this time

Please note any differing opinions that still exist at the conclusion of your discussions

Education and Conferencing

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6. Please list the titles of *current* staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. (We will discuss future staffing during our face to face meeting.) An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Site A						
Information Services						
Medical Records						
QA/Incident Rev						
Staff Developm't						
Switchboard/ Communications	4	4	3	?	Both	No
Angela Mayweather						
Annette Gates						
Char Jones						
Kiera Abram						
Education and Conferencing						

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8

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site B						
Information Services						
Medical Records						
QA/Incident Rev						
Staff Developm't						
Switchboard/ Communications						
Education and Conferencing						

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9

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7. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, staff movement or supervision needs.

Between (function/area)	And (function/area)	Reason
Mailroom	Storeroom	Possible shared services
		Dock requirement
	Operations	Emergency services

Please note any differing opinions that still exist at the conclusion of your discussions.

architecture+

10

7. Adjacency Requirements (continued)

Describe critical **ideal future external adjacency relationships** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. Again, please think about it from you understanding of the future patient profile and a new facility/environment.

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day
EES – Mailroom	1	C	
EES – Operations	2		

Please note any differing opinions that still exist at the conclusion of your discussions.

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8. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
None		

9. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

architecture+   12

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Information Technology & Integration

Information Services
Medical Records
Quality Assurance, Incident Reporting
Staff Development
Switchboard/Communications
Education & Conferencing
Electronic/Data/Systems Integration

March, 2015

Completed By: Name: Matt Krueger   Contact (phone or email)

EES	Steve Delgado x7335
	Sandra Del Pizzo x5101
	James Wacholz x6129
	Greg Kurzynski x4859
	Matt Krueger x 7877

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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1

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

architecture+

2

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Program Description

1.1 Please provide a brief narrative that summarizes the current scope/operations for each of the programs/services listed below

Information Services
IMSD oversees the support of technology at BHD. This includes:

- The network that all information flows on, including telephony

- Applications that the business uses to operate

- Hardware and infrastructure that runs the systems

- Management of externally hosted systems

- End user support, 3 tiers including onsite

- Business Analysis and Project Management

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Telephone services including internal code calls (behavioral and medical), emergency (911) calls, emergency monitoring and announcements (public address) and 2 way radios/base station. Mail services including mail receipt, sorting, distribution and outgoing (metering). Other services include copy production, laminating services, I.D. card production and parking permitting.

Education & Conferencing Services and Facilities

1.2 Please provide your thoughts on the changes that will occur to the nature of each of the services and systems as a result of moving into a new facility with fewer total beds (there could be an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, new strategies for computerization and moving more into an electronic world, etc.)

Information Services
We do not see the nature of the services changing

Medical Records, including Electronic Health Record, integrated patient data/clinical information

Switchboard/Communications

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None

Quality Assurance/Incident Review

Staff Development

Education & Conferencing Services, Facilities and Systems

Administrative and Financial Reporting Systems

Building Automation Systems

None expected

Integrated Security Systems (patient security systems, entry/exit security systems, staff personal security/alarm systems, etc.)

Addition of Pendant Duress System (individual panic alarms), key card access, metal detection

2. List the main program elements (spaces or functions) currently of each area.   This includes key features of your program. Please focus also on elements that relate to shortcomings of you area in relation to you concept of the ideal patient care, service delivery and/or staff environment.

   Information Services
   Onsite desktop, network/telephonic & application support resources each require a desk. In addition there is onsite project management staff that require desks and a business analyst who does not physically reside at BHD.

   Medical Records

   Quality Assurance/Incident Review

   Staff Development

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Francis Pitts 5/20/15 7:35 AM
Comment [1]: Confirm number of desks

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Switchboard/Communications

Mail and communication services are currently located in the same program space. Minor issues with noise from mail services and telephone reception. HIPAA issues?

> **Francis Pitts 5/20/15 7:36 AM**
> **Comment [2]:** Who sorts mail? Is it a full time job? Who answers phone? Is it a full-time job? What is the HIPPSA ssue?

Education and Conferencing

3. Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

Information Services
The biggest issue we see functionally or from a workflow perspective is how spread out the facility is. This requires more time for some of the support resources to get their work done and the time it takes to resolve issues. In addition the age and technical infrastructure of the facility makes it more challenging to support from a wireless & networking perspective.

Onsite we have the following resources:

- 1 desktop support resource
- 1 Network/telephony resource
- 1 application support resource
- 2 project mangers
- 7 EMR implementation contractors

> **Francis Pitts 5/20/15 7:37 AM**
> **Comment [3]:** Will implementation contractirs be on-site post occupancy?

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

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The mailroom houses both the communications area and mail/office services. As noted, this leads to minor issues with sound (hearing telephone reception) and, potentially, HIPAA issues (overheard conversations?). Also, due to staffing cut backs, mailroom employees have been cross-trained to work in Operations office and storeroom. These locations are separated from the mailroom by a building and floor.

Education and Conferencing

architecture+

6

4. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

Information Services
The biggest one for us would be improved proximity, both amongst our team but more importantly with end users to facilitate better communication and quicker turnaround times. In the future state our vision is more centralization of support.

Medical Records

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Separation of mail and communication services but closer to other Operations functions

Education and Conferencing

5. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Information Services
The EMR will be implemented so will not need all of the implementation resources. We envision a smaller more centralized EMR support team.

Medical Records

Quality Assurance/Incident Review

architecture+

7

Francis Pitts 5/20/15 7:38 AM
Comment [4]:

Staff Development

Switchboard/Communications

None anticipated at this time

Please note any differing opinions that still exist at the conclusion of your discussions

Education and Conferencing

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6. Please list the titles of **current** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. (We will discuss future staffing during our face to face meeting.) An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site A						
Information Services						
Desktop Support	1	1	1	Infrequent		
Telecom Support	1	1	1	Infrequent		
Application Support	1	1	1	Infrequent		
Project Mgmt	1.5	2	2	Infrequent		
EMR Implementation	4	4	4	Infrequent		
EMR Support	3	3	3	Infrequent		
Medical Records						
QA/Incident Rev						
Staff Developm't						
Switchboard/ Communications	**4**	**4**	**3**	**?**	**Both**	**No**
Angela Mayweather						
Annette Gates						
Char Jones						
Kiera Abram						
Education and Conferencing						

Francis Pitts 5/20/15 7:39 AM

Comment [5]: Discuss staffing by shift

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site A						

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site B						
Information Services						
Medical Records						
QA/Incident Rev						
Staff Developm't						
Switchboard/ Communications						
Education and Conferencing						

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Site B						

architecture+   11

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7. Adjacency Requirements

Describe *ideal critical internal adjacency relationships* within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, staff movement or supervision needs.

Between (function/area)	And (function/area)	Reason
I.S. Support resources	Centrally located	More efficient support

Please note any differing opinions that still exist at the conclusion of your discussions.

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7. Adjacency Requirements (continued)

Describe critical *ideal future external adjacency relationships* that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. Again, please think about it from you understanding of the future patient profile and a new facility/environment.

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day
None			

Please note any differing opinions that still exist at the conclusion of your discussions.

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13

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8. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
None		

9. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

architecture+

14

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Information Technology & Integration
Information Services
Medical Records
Quality Assurance, Incident Reporting
Staff Development
Switchboard/Communications
Education & Conferencing
Electronic/Data/Systems Integration

March, 2015

Completed By: Name: Contact (phone or email)

Name	Contact (phone or email)
Vicki Wheaton	414-257-6953

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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architecture+

PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Program Description

1.1 Please provide a brief narrative that summarizes the current scope/operations for each of the programs/services listed below

Information Services

Medical Records
Maintain a complete and accurate legal Medical Records. This includes release of information, scanning of documents into EMR, coding and analysis of records.

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Education & Conferencing Services and Facilities

1.2 Please provide your thoughts on the changes that will occur to the nature of each of the services and systems as a result of moving into a new facility with fewer total beds (there could be an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, new strategies for computerization and moving more into an electronic world, etc.)

Information Services

Medical Records, including Electronic Health Record, integrated patient data/clinical information

On-site at the new hospital will maintain the release of information function.

Coding, Analysis and scanning can be moved to an administrative area. Courier will need to be in place to deliver documents to be scanned into the records.

Francis Pitts 5/20/15 3:06 PM
Comment [1]: Staffing. On site (1 staff)

Francis Pitts 5/20/15 3:05 PM
Comment [2]: Off-site

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3

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Switchboard/Communications

Quality Assurance/Incident Review

Staff Development

Education & Conferencing Services, Facilities and Systems

Administrative and Financial Reporting Systems

Building Automation Systems

Integrated Security Systems (patient security systems, entry/exit security systems, staff personal security/alarm systems, etc.)

2. List the main program elements (spaces or functions) currently of each area.   This includes key features of your program. Please focus also on elements that relate to shortcomings of you area in relation to you concept of the ideal patient care, service delivery and/or staff environment.

    Information Services

    Medical Records
    Release of information-Outsourced Health port sits at the receptionist desk and handles calls for ROI and patient pick up of records.

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Release of information BHD employee for non-billable request and alerts can be housed in an administrative area. OFF SITE

Release of information Coordinator/Coder-Administrative area. OFF-SITE

Record Completion Coordinator –Administrative area. . OFF-SITE

5 Clerical positions for scanning and analyzing of records. . OFF-SITE

Area for 2 scanners-printers and large copier. . OFF-SITE

> **Francis Pitts 5/20/15 7:45 AM**
> **Comment [4]:** Which are on-site at the hospital?

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Education and Conferencing

3. Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

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Information Services

Medical Records
None

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Education and Conferencing

architecture+

6

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4. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

Information Services

Medical Records

Would like staff to be together in one room. Currently very split up throughout the department.

Quality Assurance/Incident Review

Staff Development

Switchboard/Communications

Education and Conferencing

architecture+   7

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5. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

   Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

   Information Services

   Please note any differing opinions that still exist at the conclusion of your discussions

   Medical Records

   None

   Please note any differing opinions that still exist at the conclusion of your discussions

   Quality Assurance/Incident Review

   Please note any differing opinions that still exist at the conclusion of your discussions

   Staff Development

   Please note any differing opinions that still exist at the conclusion of your discussions

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8

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Switchboard/Communications

Please note any differing opinions that still exist at the conclusion of your discussions

Education and Conferencing

Please note any differing opinions that still exist at the conclusion of your discussions

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6. Please list the titles of **current** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. (We will discuss future staffing during our face to face meeting.) An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site A						
Information Services						
Medical Records	10	10	12		dedicated	2
			One for viewing records for patients			
			Additional for light duty workers			
QA/Incident Rev						
Staff Developm't						
Switchboard/ Communications						

Francis Pitts 5/20/15 3:08 PM
Comment [5]: On-site vs off-site. 1 PESON ON-SITE …REST IS OFF-SITE.

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Site A						
Education and Conferencing						

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Site B						
Information Services						
Medical Records						
QA/Incident Rev						
Staff Developm't						
Switchboard/ Communications						
Education and Conferencing						

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site B						

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7. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, staff movement or supervision needs.

Between (function/area)	And (function/area)	Reason

Please note any differing opinions that still exist at the conclusion of your discussions.

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13

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7. Adjacency Requirements (continued)

Describe critical *ideal future external adjacency relationships* that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. Again, please think about it from you understanding of the future patient profile and a new facility/environment.

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day

Please note any differing opinions that still exist at the conclusion of your discussions.

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8. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

9. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

architecture+   15

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Information Technology & Integration

Information Services
Medical Records
Quality Assurance, Incident Reporting
Staff Development
Switchboard/Communications
Education & Conferencing
Electronic/Data/Systems Integration

March, 2015

Completed By: Name: Contact (phone or email)

(LEAD)	

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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architecture+

PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6.   The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7.   Please state when information is not available or estimates are provided as answers to any questions.

8.   If any question does not relate to your department, please indicate "Not Applicable".

9.   It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

architecture+   2

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Program Description

1.1 Please provide a brief narrative that summarizes the current scope/operations for each of the
   programs/services listed below

   Information Services

   Medical Records

   Quality Assurance/Incident Review

   Staff Development
   *We educate the staff in the hospital as the need arises. We do all orientations, The Joint
   Commission readiness pieces, vendor trainings on hospital policies, CPR trainings, etc. We
   educate CNAs, RNs and MDs. We develop training materials. We do both in person and on line*
   educations. We develop curriculum. We do research for all educational presentations.

   Switchboard/Communications

   Education & Conferencing Services and Facilities

1.2 Please provide your thoughts on the changes that will occur to the nature of each of the
   services and systems as a result of moving into a new facility with fewer total beds (there could
   be an overall change to the acuity or treatment needs of the patients, new opportunities in
   treatment programming that will be possible in a new facility, new strategies for
   computerization and moving more into an electronic world, etc.)

   Information Services

   Medical Records, including Electronic Health Record, integrated patient data/clinical information

   Switchboard/Communications

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Quality Assurance/Incident Review

Staff Development
I believe that moving into the community will allow our department to get out into the community and educate more people about mental health issues. Also, potentially have programs for patients so they will understand their illness better. I think this move will provide opportunities for Staff Development that we currently cannot realize.

Education & Conferencing Services, Facilities and Systems

Administrative and Financial Reporting Systems

Building Automation Systems

Integrated Security Systems (patient security systems, entry/exit security systems, staff personal security/alarm systems, etc.)

2. List the main program elements (spaces or functions) currently of each area. This includes key features of your program. Please focus also on elements that relate to shortcomings of you area in relation to you concept of the ideal patient care, service delivery and/or staff environment.

Information Services

Medical Records

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Quality Assurance/Incident Review

Staff Development

Our department is currently an old patient unit. We are located as far as we can be away from the acute units. It can be designed to be more efficient. The department will need to have a CENTRAL LOCATION

- *office for the director* **at hospital**
- *cubicles for the other four staff* **at hospital**
- *Computer training lab totaling 650 sq.ft.* **at hospital**
- *CPR room 375 sq. ft.* **at hospital**
- *Restraint room 200 sq. ft.* **at hospital (combine with above)**
- *Main teaching room- Three rooms totaling 1650 sq. ft. divided into three rooms with retractable walls so the room could be used in its entirety or subdivided for separate training all three rooms would need drop down projectors and screens and all would need smart boards on the walls.* **at hospital**
- *A staging room for copying materials and storing needed materials for trainings* **at hospital**
- *AV materials storage area;* **at hospital**
- *Kitchen for making coffee, setting up water and snacks for the staff.*
- *Admin assist work area* **at hospital**
- *Student break room approximately 250 sq. ft. with refrig and microwave* **at hospital**
- *Good lighting throughout department*
- *20 laptops for all students*
- *Reliable WIFI in all areas of the department*

Switchboard/Communications

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Education and Conferencing

3. Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

Information Services

Medical Records

Quality Assurance/Incident Review

Staff Development
Unreliable WIFI

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Switchboard/Communications

Education and Conferencing

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7

4. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

Information Services

Medical Records

Quality Assurance/Incident Review

Staff Development
Technology – 20+ laptop computers that would be able to work simultaneously off of the WIFI

Switchboard/Communications

Education and Conferencing

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5. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Information Services

Please note any differing opinions that still exist at the conclusion of your discussions

Medical Records

Please note any differing opinions that still exist at the conclusion of your discussions

Quality Assurance/Incident Review

Please note any differing opinions that still exist at the conclusion of your discussions

Staff Development
We may want to invite the public into our facility for seminars. A conferencing center should be developed to accommodate this need. It could also be the room where the board meets, have management meetings etc.

More training moving to online

architecture+   9

Francis Pitts 5/20/15 7:49 AM
Comment [3]:

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Unforeseen regulatory changes

Changes in number of patients being served

Numbers of new staff requiring onboarding

Francis Pitts 5/20/15 7:50 AM
Comment [4]:

Please note any differing opinions that still exist at the conclusion of your discussions

Switchboard/Communications

Please note any differing opinions that still exist at the conclusion of your discussions

Education and Conferencing

Please note any differing opinions that still exist at the conclusion of your discussions

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6. Please list the titles of **current** staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. (We will discuss future staffing during our face to face meeting.) An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site A						
Information Services						
Medical Records						
QA/Incident Rev						
Staff Developm't	5	5	1/4	1 clerical		
Director						
coordinator						
coordinator						
coordinator						
System analyst						
Switchboard/ Communications						
Education and Conferencing						

Francis Pitts 5/20/15 7:50 AM
Comment [5]: On-site vs off-site

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site B						
Information Services						
Medical Records						
QA/Incident Rev						
Staff Developm't						
Switchboard/ Communications						
Education and Conferencing						

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7. Adjacency Requirements

Describe *ideal critical internal adjacency relationships* within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, staff movement or supervision needs.

Between (function/area)	And (function/area)	Reason
QA/Ed Services	Coping and staging area	We work together on many projects
Close to all inpatient units		Clinical staff can come to educational trainings and minimize time off the units

Please note any differing opinions that still exist at the conclusion of your discussions.

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7. Adjacency Requirements (continued)

Describe critical **ideal future external adjacency relationships** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. Again, please think about it from you understanding of the future patient profile and a new facility/environment.

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A – Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day
HR	2	New staff frequently need to talk with HR	several
Avatar Support/ IMSD	1	Frequently need to talk with IMSD regarding staff needing to change passwords etc.	several
Nursing Admin	2	Variety of meetings with nursing Admin	several
Staffing	3		
EES	3		
Mailroom	3		
Dietary	3		
Storeroom	3		
Central supply	3		
Units	1	Staff need education	several

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Please note any differing opinions that still exist at the conclusion of your discussions.

8. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
Space	Nursing admin uses sometimes	
Space	Annual flu and TB skin tests Infection control	Space
Space	We share our space with all BHD staff that require training in CPR, Mandt, Corrective action training, NEO, demos on new products brought into hospital	

9. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

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Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Dietary Services

March, 2015

Completed By: Name: Contact (phone or email)

(LEAD)	
Gaylyn Reske	Gaylyn.Reske@milwaukeecountywi.gov
Larry Johansen	
Barbra Livermore	

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Program Description

1.1 Please provide a brief narrative that summarizes the current scope/operations of your Dietary Department. Please be sure to identify the on-unit services to the patients of the Facility.

The Dietary Department provides two main services which are Foodservice Operations and Clinical Dietetics.

Clinical Dietetic Services include Medical Nutrition Therapy and dietary counseling to patients by two Registered Dietitians.

The hospital foodservice provides three meals and snacks to all acute care patients, the remaining long term care residents and lunch four times per week to the Day Treatment Clients. Food is prepared at an off-site kitchen facility and transported to the hospital at serving temperature. The acute care units and day treatment clients are served on meal delivery trays which are assembled in the trayline area, delivered to the unit by dietary staff, and then distributed to patients by nursing staff. The dietary department is responsible for returning the carts containing the dirty dishware to the foodservice area for cleaning. The long-term care residents have kitchenette service. The meals are delivered to the units in bulk, plated by a dietary employee, distributed by unit staff and the dishes are washed on the unit by dietary employees. At the present time the dishmachine at the BHD trayline is not operating and dirty dishes are transported to the old foodservice building for cleaning.

The foodservice department is operated by a contract management company.

1.2 Please provide your thoughts on the changes that will need to occur to the nature of the food services production, delivery and meal service as a result of moving to a facility with fewer total beds than your systems were originally designed to support (this reduction in bed count is likely to bring an overall increase to the acuity and functional disabilities of the patients); there may also be new opportunities in meal production and service styles, etc.

The current facility does not have the capability to produce meals. The lack of a hood system prohibits heat and smoke generating equipment from being installed. There is limited dry storage and cold storage space. Until the beginning of this year the production kitchen north of Watertown Plank Road between the Ronald McDonald House and WE Energies Power Plant was used for meal production. This building is old and in poor repair. Utility costs associated with running the foodservice building are very high considering the amount of food that is being prepared.

There are two potential patient meal service methods, these are tray service or kitchenette service. Meal trays offer a more controlled dining experience but also is appears institutional. Kitchenette service provides for a more appealing and patient-centered meal experience, but may present a challenge in units that have patients who are more aggressive and volatile.

Francis Pitts 5/20/15 8:15 AM
Comment [1]:

Francis Pitts 5/21/15 5:53 AM
Comment [2]: Will this continue? . How many FTE's are committed to transport? Does the kitchen serve others? Will it in future? Current transport distance?

Francis Pitts 5/20/15 8:17 AM
Comment [3]: Off site?

Francis Pitts 5/20/15 8:17 AM
Comment [4]: Off site?

Francis Pitts 5/20/15 8:16 AM
Comment [5]: Not applicable?

Francis Pitts 5/21/15 5:53 AM
Comment [6]: Discuss

architecture+

3

2. List the main program elements (spaces or functions) currently of each area.   This includes key features of your program. Please include information on the dietary services provided on the resident care units. Please focus also on elements that relate to shortcomings of you area in relation to you concept of the ideal patient care, service delivery and/or staff environment.

    There are 2 areas on the acute units that are pertinent to the patient's food and dining experience.

    The kitchenette area which is secured from patient access is used to store patient snacks and nourishments in cold or dry storage. Unfortunately, the staff often use this area to make coffee for themselves and store their lunches, etc. The staff do not often clean this area. Since patient food is being store in these areas, they can be subject to inspection. Perhaps the staff could have a small area of their own which is located very near the units to prevent this from occurring.

    The current Dining Rooms often act as multi-purpose areas. The natural day light is very nice, but otherwise the dining areas are not very inviting. We would not recommend the TV be located in a dining area.

> **Francis Pitts 5/20/15 8:19 AM**
> **Comment [7]:** Will do!

> **Francis Pitts 5/20/15 8:19 AM**
> **Comment [8]:** Will program separate from activity nd TV….but still multi-purpose.

3. How and when will food be transported to the inpatient units (meals and nourishments)?

    Ideally, meals, snacks and nourishments would be delivered in a manner which would not pass through patient care areas. For example, access to kitchen pantry through a hallway door. Meals will be delivered 3 times per day, snacks would be delivered/stocked once per day.

4. How many carts are used for the building? How big will the carts be in terms of size and number needed per unit per meal?

    2 meal delivery carts would be needed for each patient unit. Cart capacity will depend on maximum beds per patient unit. Cart type will also depend on the method of meal service. (tray vs serving kitchen)

    Serving kitchen would require a 2 cavity cambro cart (one hot cavity one cold cavity)

> **Francis Pitts 5/20/15 8:20 AM**
> **Comment [9]:**

5. Is a holding area required if deliveries are not timed for individual meals? If so, what cart manufacturer and model number is anticipated?

    Meals should be distributed by unit staff within 15 minutes of meal delivery. Meal carts should not be left in an area where patients can gain access to the food without supervision.

6. How many sittings will be scheduled at each meal for each dining room?

    1

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7. Will dining occur on the unit or at a central location within the building? How and when are carts returned to the kitchen?

   On the unit. Carts are picked up by dietary staff after meals for dishware and cart cleaning.

8. Will service be family style, pre-plated or service line? If pre-plated, how will the need for seconds be accommodated?

If a serving pantry is used, seconds could be addressed on the unit, though "seconds" are a not usually encouraged on the adult in-patient units.

9. What accommodations need to be provided at the Dining Room for beverage storage and distribution?

Each pantry should have a reach in cooler/freezer, ice and water machine, coffee maker with hot water capability would be desirable if kitchenette service style is to be used.

10. Where will service ware, plates and cutlery be washed?

   Main kitchen.

> Francis Pitts 5/20/15 8:20 AM
> **Comment [10]:** Off-site?

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11. Please describe the current internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

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12. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

A kitchen operation that is centrally located to all units would improve labor efficiency greatly. Time transporting carts to and from locations that are not close by and require elevator usage can result in more labor being used than what could be used if a kitchen was near the patient units.

The layout of the kitchen should be in line with the flow of food from receiving, storage, preparation and assembly. Kitchen should not be far from delivery dock.

Please note any differing opinions that still exist at the conclusion of your discussions

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13. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external, equipment or industry changes.*

Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

Current operation is not environmentally friendly. Could do a better job with recycling. Need to consider composting.

Farm to table and less processed foods are starting to make their way into institutional/commercial kitchens. Companies are beginning to support locally grown food. This could require cooler space and capabilities for more frequent deliveries.

It is the Dietitians hope that wellness education and activities will be enhanced and encouraged for our patients. Promoting healthy eating, physical activity and a well-balanced lifestyle is key to improving the physical health of our patients. We would like to see the patients treated as a whole (mind, body, spirit).

Francis Pitts 5/20/15 8:21 AM
Comment [11]:

Please note any differing opinions that still exist at the conclusion of your discussions

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14. Please list the titles of **current** staff and number of FTE's and Bodies of each area within Dietary Services and note if an office or workstation is needed. We will discuss fuure staffing needs during our face to face meeting. An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, visitors) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Dietitian Supervisor	1	1	Office	5	dedicated	
Clinical Dietitians	2	2	Office	1	dedicated	
Foodservice Manager	2.5	3	Office	3	dedicaed	
Foodservice Supervisor	2	2	workstation	-	multiuse	
Dietary Aide	15	16	---	---		
Cook	1	2	workstation	0	multiuse	

Francis Pitts 5/20/15 8:22 AM
Comment [12]:

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15. Adjacency Requirements

Describe **ideal critical internal adjacency relationships** within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason
Foodservice Management	Main Kitchen/production area	supervision
Clinical Dietitians	Foodservice Management	communication

Please note any differing opinions that still exist at the conclusion of your discussions.

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15.1   Adjacency Requirements (continued)

Describe critical ***ideal future external adjacency relationships*** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. Again, please think about it from your understanding of the future patient profile and a new facility/environment.

CLOSENESS INDICATOR	REASON INDICATOR
1 - Directly next to	A - Resident movement
2 - Same floor	B - Staff movement
3 - Doesn't matter	C - Materials movement

Department	Closeness	Reason	Contacts/Day
EES	2	C	1
Central Supply	2	C	1
Human Resources	3	B	
Therapy	3	B	
Education Services	2	B	
Nursing Administration	2	B	

Please note any differing opinions that still exist at the conclusion of your discussions.

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16. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing

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17. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

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5.7. Dining Room (FSCD1) - 700 NSF [65.0 NSM]
Serving/Pantry (FSPT1) - 235 NSF [21.8 NSM]
Floor Plan

Milwaukee County Behavioral Health Department
Replacement Hospital Program Study

Appendix E - Questionnaire Responses and Data
Page E-242

Hospital Programming Project

for the

Milwaukee Board of Behavioral Health

Questionnaire for:

Facilities Management Services
Environmental Services (Housekeeping)
Laundry & Linen Supply
Maintenance Shops
Central Supply/Central Stores/Warehousing
Employee Lockers
Security
Fire/Safety

March, 2015

Completed By: Name: Contact (phone or email)

Name	Contact (phone or email)
EES Team	Delgado, Steve: 257-7335
	Greg Kurzynski; 257-4859
	Sandy Del Pizzo; 257-5101
	Jim Wacholz; 257-6129
	Mike McAdams;

Please return this questionnaire by Friday, April 10, 2015
to Mr. Francis Pitts, pittsf@aplususa.com

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PURPOSE OF THIS QUESTIONNAIRE

This questionnaire has been developed by the Planning Team to assist in collecting programming and planning information for the design of a state-of-art treatment facility for adults with serious and persistent mental illness, to replace the current programs and facilities at Milwaukee County Mental Health Center.

You are requested to answer the questionnaire for the areas (programs, services and facilities) for which you have responsibility. You are requested to respond to the questionnaire from the collective viewpoint, therefore all identified representatives covering each department/ service will need to meet and discuss the issues in the questionnaire to create a combined response (please see below for a description of this process). For questions or issues where there are clearly different viewpoints, we ask that you briefly outline these for us. Such differences may relate to culture, treatment philosophies/ approach, roles and responsibilities or ideal facilities/patient care environment, in moving into the future.

In all cases, we ask you to think about your new future, a future that provides for you new treatment and service environments, new technologies and the like.

The questionnaire's purpose is as follows:

- To assist the Planning Team in analyzing the current and future activities of hospital departments
- To communicate information about the Hospital's current and future programs and services to the Planning Team
- To serve as a tool for the Planning Team in evaluating demands and needs of departments
- To assist in the development of a database useful in planning activities.

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

1. Read all questions carefully before answering any part of the questionnaire.

2. Each of the designated individuals who has primary responsibility for the department/services covered should complete the questionnaire, particularly related to the existing services and facilities. We also ask that you think about the future (5 to 10 years from now)

3. A Briefing and Visioning Session is scheduled for March 27th. Please bring your questionnaire responses and thoughts about the future to this planning day. Following the visioning session, the representatives for all services will be asked to get together as groups to review their responses and determine what the collective response should be. Where there is a divergence of opinion regarding any particular question, space is provided to document this for our planners. We value multiple points of view.

4. At this review session, the identified lead individual will then complete the consolidated questionnaire.

5. Each question should be answered by entering the information requested or by entering the numerical value requested in the spaces provided. It is hoped that the questionnaire can be completed electronically. Any added information that is in electronic format should be appended to the email to which the response is returned (or a subsequent email, depending

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on the capacity of the email system). Any additional material that is hard copy should be scanned and emailed or faxed.

6. The sources of information should be cited if applicable (i.e. Committee Meeting Minutes or Monthly Medical Record Report).

7. Please state when information is not available or estimates are provided as answers to any questions.

8. If any question does not relate to your department, please indicate "Not Applicable".

9. It is requested that the nominated 'lead' assemble the collected response on April 9, 2015.

10. Please forward your completed consolidated questionnaire to Francis Pitts by April 10, 2015. Forwarding it as an electronic document attached to the following email address is preferred: pittsf@aplusus.com

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Program/Service Description:

1.1 Please provide a brief narrative that summarizes the current scope/operations for each of the programs/services listed below

Environmental Services
Responsible for all hospital and office cleanliness, linen delivery, trash removal, biomedical waste removal and recycling. This service is currently outsources.

Laundry & Linen Supply
Sort and supply hospital units with clean linen and clothing. Maintain hospital inventory of clothing and linens. The linen currently is laundered elsewhere (outsourced).

Maintenance Shops
Responsible for the mechanical upkeep and safe operation of the hospital and grounds.

Central Supply/Central Stores/Warehousing
Supply medical, non-medical and office supplies for the hospital. Maintain hospital inventory of medical, non-medical and office supplies.

Employee Lockers
Record and assign lockers for employee use.

Transportation (and/or Grounds)
Maintenance services all of the Milwaukee County vehicles used by hospital staff.

** does not include transportation of patients.

Security
Responsible for maintaining a secure environment for hospital staff, clients and visitors.

Fire/Safety
Responsible for maintaining and inspecting all non-medical life safety devices and systems within the hospital.

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1.2 Please provide your thoughts on the changes that will occur to the nature of the program and its services in moving to a new facility with fewer total beds (this could be related to an overall change to the acuity or treatment needs of the patients, new opportunities in treatment programming that will be possible in a new facility, etc.)

Environmental Services
Hospital: Adjust staffing levels based upon building design and layout.
Hubs: Consolidation of staff and resources with ability to mobilize to alternate locations/hubs

Laundry & Linen Supply
Hospital: Adjust staffing levels based upon building design and layout.
Hubs: Consolidation of staff and resources with ability to mobilize to alternate locations/hubs. Potential for HOC to deliver to each location?

Maintenance Shops
Hospital: Adjust staffing levels based upon building design and layout.
Hubs: Consolidation of staff and resources with ability to mobilize to alternate locations/hubs

*Note: Staffing levels will also have to be determined based upon unanticipated maintenance needs such as: Power plant operations, etc.

Central Supply/Central Stores/Warehousing
Hospital: Adjust staffing levels based upon building design and layout.
Hubs: Consolidation of staff and resources with ability to mobilize to alternate locations/hubs

Employee Lockers
Maintain appropriate amount of lockers to accommodate staff.

Transportation (and/or Grounds)
Require additional vehicles for staff mobilization (deliveries, etc)

Require the use of a pick up truck or vehicle to deliver supplies to the community hubs. Currently have a box truck, pick up truck, SUV, 2 front loaders, all-terrain vehicle for plowing, and hauling grounds parts.

Security
Adjust staffing levels based upon building design and layout and available technology to support a 24/7 operation.

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Fire/Safety
Adjust ATG (LS and Permitting; compliance) and TMS/4Rivers (work orders) for multiple locations

2. List the main program elements (spaces or functions) currently of each area.   This includes key features of your program. Please focus also on elements that relate to shortcomings of you area in relation to you concept of the ideal patient care, service delivery and/or staff environment.

Environmental Services
Hospital: Key features will include but not limited to: clean loading dock, soiled loading dock, supply storage, temporary supply storage, recycling space, equipment space, compactor rooms, office space, chemical storage, battery charging stations, automated wheelchair washing/equipment and washing.

Hubs: clean and soiled docks/entrances, supply storage, temporary storage, chemical storage; vehicle parking

Laundry & Linen Supply
Hospital: clean dock, storage space, mending room, equipment room, commercial washer and dryer space, stamping machine/clothing marking and linen cart storage.

Hubs: clean/soiled entrances, commercial washer/dryer; cart storage; vehicle parking

Maintenance Shops
Hospital: Mechanical shop, electrical shop, carpenter shop, HVAC shop, plumbing shop, equipment repair space, material storage, assembly area, staging area, office space, kiosk space, vehicle storage space, small engine repair, grounds equipment storage, chemical storage, weld shop, paint shop, locksmith, hazardous material/waste areas, tool crib, blueprint room and cart storage.

Hubs: mechanical shop/office; material/chemical storage; vehicle parking (providing a centralized maintenance department as noted above is available).

Central Supply/Central Stores/Warehousing
Hospital: Loading dock, material storage, oxygen storage, cart storage, medical equipment storage, office space, kiosk space, clean area and recycling.

Hubs: Clean storage room at each location. Add'l staff required to monitor/distribute supplies at each location?? (Providing a centralized distribution department as noted above is available).

Employee Lockers
Provide appropriate number of locker to accommodate staffing levels in a 24/7 operations.

Transportation (and/or Grounds)
(Centralized) Vehicle parking, vehicle storage, vehicle maintenance, equipment storage and maintenance.

| Francis Pitts 5/20/15 8:02 AM |
| **Comment [1]:** |

| Francis Pitts 5/20/15 8:02 AM |
| **Comment [2]:** |

| Francis Pitts 5/20/15 8:03 AM |
| **Comment [3]:** |

| Francis Pitts 5/20/15 8:03 AM |
| **Comment [4]:** |

| Francis Pitts 5/20/15 8:03 AM |
| **Comment [5]:** |

| Francis Pitts 5/20/15 8:03 AM |
| **Comment [6]:** |

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Security
Hospital: Offices, monitoring center, assembly room, guard station, employee/public entrance stations, vehicle storage.

Hubs: Add'l cameras, and possibly staff (FTEs), for each location. Centralized monitoring or oversight? Security office and guard station(s). Vehicle parking.

Fire/Safety
Appropriate to code. Centralized monitoring?

Please describe the internal operations and functions of each area. Please discuss any problems or problem areas that affect the smooth functioning of each area. An example of this would be work areas that are located in several places across the Facility fragmenting workflow, supervision, etc.

Environmental Services
Service entrance for staff and carts.

Laundry & Linen Supply
Service entrance for staff and carts.

Maintenance Shops
Service entrance for staff and carts.

Central Supply/Central Stores/Warehousing
Service entrance for staff and carts.

Employee Lockers
Lockers adjacent to employee work areas.

Transportation (and/or Grounds)
A garage to house and service vehicles.

Security
Increase space for monitoring and station space.

Fire/Safety
Emergency vehicle access to the facility and protection from inclement weather (sallyport).

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Francis Pitts 5/20/15 8:04 AM
Comment [7]:

Francis Pitts 5/20/15 8:04 AM
Comment [8]:

3. Please indicate if there are any operational changes that would improve the efficiency of each area, in particular any physical features that could make your area more efficient.

    Environmental Services
    Laundry & Linen Supply
    Maintenance Shops
    Central Supply/Central Stores/Warehousing
    Employee Lockers
    Security
    Fire/Safety

    See question 3.

    Please note any differing opinions that still exist at the conclusion of your discussions

    Transportation (and/or Grounds)

    See question 3. Emergency vehicle access to the facility and protection from inclement weather (sallyport).

> Francis Pitts 5/20/15 8:04 AM
> **Comment [9]:**

4. Please describe any anticipated changes that may occur within the next five years that might have a significant impact on each area's operation, where these have not been covered in earlier questions. *These changes are most likely to be the result of external or industry changes.*

    Some items that you might discuss here are: planning issues/trends, new services, new methods of delivering care/services, personnel, equipment, adjustments to operating costs, method of operation, etc. This includes important executive directives or licensing objectives that may impact space requirements or influence locations or adjacencies.

    Environmental Services
    Laundry & Linen Supply
    Maintenance Shops
    Central Supply/Central Stores/Warehousing
    Employee Lockers
    Transportation (and/or Grounds)
    Security
    Fire/Safety

    Unknown at this time. Dependent upon administrative decision regarding future "Look" of County Behavioral Health (single building vs locational hubs).

    Please note any differing opinions that still exist at the conclusion of your discussions

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5. Please list the titles of *current* staff and number of FTE's and Bodies of each area and note if an office or workstation is needed. (We will discuss future staffing during our face to face meeting.) An office would be required if confidential conversations take place in the course of daily work. For offices that will also host others from outside the area (other staff, multiple clients or visitors/family members) please indicate the "usual" number of such others that would be present in the office – this will enable us to appropriately size the offices for the most common situations. Are any of the staff transients? Are there individuals that may only be in the area for short periods of time and only occasionally – ie hoteling areas (access to a workstation for short periods of time in the day) for some staff or outside organizations?

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site A						
Environmental Services	40	40	2	5	No	No
Laundry & Linen Supply	3	3	2	0	dedicated	No
Maintenance Shops	20	20	5	8	Dedicated and multiuse	no
Central Supply/ Central Stores/ Warehousing	4	4	4	3	Dedicated	no
Employee Lockers						
Transportation and/or Grounds						
Security	33	37	4	0	Dedicated and	No

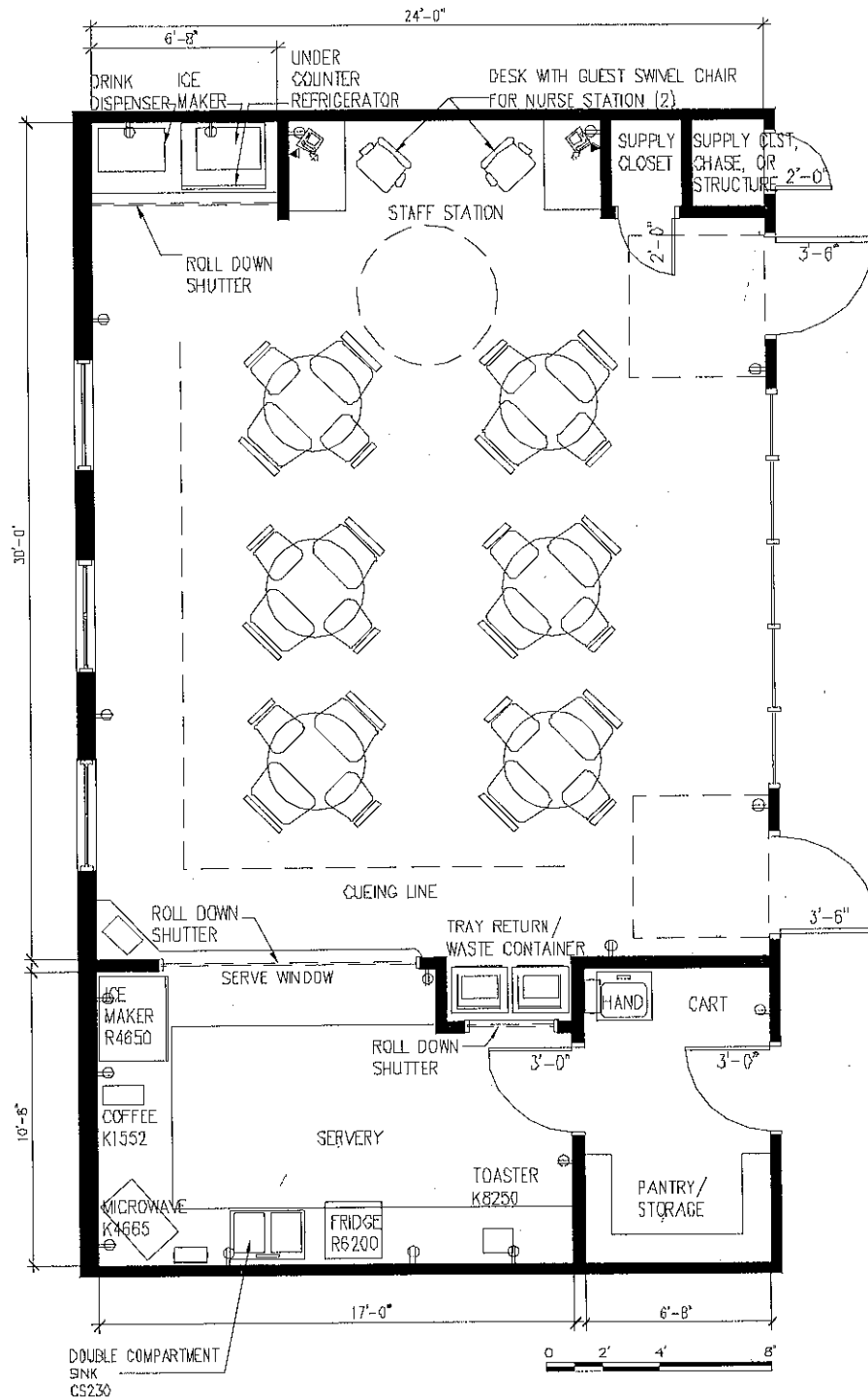**architecture+**   9

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site A						
					multiuse	
Fire/Safety			2		Dedicated and multi use	

Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi-Use	Hoteling Areas
Site B						
Environmental Services						
Laundry & Linen Supply						
Maintenance Shops						
Central Supply/ Central Stores/ Warehousing						
Employee Lockers						
Transportation and/or Grounds						

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Staff Title	FTE's	Bodies	Office/ Workstn	Usual # Visitors to office/ wrkstn	Requires Dedicated or Multi- Use	Hoteling Areas
Site B						
Security						
Fire/Safety						

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6. Adjacency Requirements

Describe *ideal critical internal adjacency relationships* within your area(s) regardless of whether these are currently achieved or not possible. These relationships may be a result of resident flow, material flows, or staff movements or supervision needs.

Between (function/area)	And (function/area)	Reason
Central Supply	Storeroom	Staff shortage
Mail Room	Storeroom	Staff shortage
Maintenance	Life Safety	Staff shortage/timely response

Please note any differing opinions that still exist at the conclusion of your discussions.

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7. Adjacency Requirements (continued)

Describe critical ***ideal future external adjacency relationships*** that each area has with other departments in the facility. These relationships may be a result of resident flow, materials flow, or staff movements. Some historic relationships may not be necessary in a more electronically connected environment.

Using the "Closeness" indicator identified below, indicate how near you should be located to the listed departments. Identify the most important "Reason" from the list below, or add explanation. Also, estimate the number of contacts you make per day with that particular department. *Again, please think about it from your understanding of the future patient profile and a new facility/environment.*

CLOSENESS INDICATOR
1 - Directly next to
2 - Same floor
3 - Doesn't matter

REASON INDICATOR
A - Resident movement
B - Staff movement
C - Materials movement

Department	Closeness	Reason	Contacts/Day
Operations	3		
Environmental Services	3		
Laundry and Linen	3		
Maintenance	3		
Security	3		
Central Supply	3		

Please note any differing opinions that still exist at the conclusion of your discussions.

Would like all of the above listed departments in one general area.

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7. Please list materials, space, personnel or other resources that you currently share with any other department(s). Please indicate which department(s) and describe the nature of the sharing.

What do you Share	Share with Whom	Nature of Sharing
Clean Utility Rooms	Clinical Staff	
Dirty Utility Rooms	Clinical Staff	
Janitors Closets	Clinical Staff	

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8. This there any other information or data that you feel the programming/planning team should be aware of that has not been requested by this questionnaire?

Emergency Operations Center and associated technologies.

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Appendix F - Space Checklist Based Upon Applicable Licensing and Accreditation Standards

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	AIA Guidelines (2.1-3.8 and 2.3: Psychiatric Hospital, 2006)	FGI/AIA Guidelines (2.1-2.5: Psychiatric Hospital, 2010)	FGI/AIA Guidelines (2.1-2.5: Psychiatric Hospital, 2014)	Citation from FGI/AIA Guidelines (2.1-2.5: Psychiatric Hospital, 2014)	Comments (per AIA/FGI Guidelines 2010 edition)	Wisconsin DHS 124
Sallyports			The primary access point to the locked unit shall be through a sally port	2.5-2.2.1		NA
Single Bedroom	100 clear (120 for geriatric)	100 clear (120 for geriatric)	100 clear (120 for geriatric)	2.5-2.2.2	For General Hospitals: A3.1.1.2 (1) In new construction, single patient rooms should be at least 12 feet (3.66 meters) wide by 13 feet (3.96 meters) deep (or approximately 160 square feet, or 14.86 square meters) exclusive of toilet rooms, closets, lockers, wardrobes, or alcoves. For IPU's on a general hospital good practice suggests a clearance of 3 feet on all sides of the bed with 4' at the foot of the bed in sem-private rooms . 3'-8" doors required for geriatric.	100
Double Bedroom	160 clear (200 for geriatric)	160 clear (200 for geriatric)	160 clear (200 for geriatric)	2.5-2.2.2	Exclusive of toilet rooms, closets, lockers, wardrobes alcoves or vestibules. For general hospitals a clearance of 4 feet (1.22 meters) shall be available at the foot of each bed to permit the passage	80 per bed
Maximum Number of Beds/Room	2	2	2	2.5-2.2.2		2
Is Window Required to be Operable	No	No	No	2.5-2.2.2		NS
Patient Bathroom	En Suite with direct access (may be disregarded if it conflicts with supervision as required in the treatment program) One toilet room shall serve no more than four beds and no more than two patient rooms.	En Suite with direct access (may be disregarded if it conflicts with supervision as required in the treatment program) One toilet room shall serve no more than four beds and no more than two patient rooms.	En Suite with direct access (may be disregarded if it conflicts with supervision as required in the treatment program) One toilet room shall serve no more than four beds and no more than two patient rooms.	2.5-2.2.2		En Suite with direct access One toilet room shall serve no more than four beds and no more than two patient rooms.
Wardrobe or Closet	Required	Required	Required	2.5-2.2.2		Required
Visual Privacy (cubicle curtains) in multi-bed rooms	No mention.	No mention.	No mention.	2.5-2.2.2		PRIVACY. Visual privacy shall be provided for each patient in multi−bed patient rooms. In new or remodeled construction, cubicle curtains shall be provided
Desk or Writing Surface	Required	Not Required	Not Required	2.5-2.2.2		(5) MINIMUM FURNISHINGS. (a) A hospital−type bed with a suitable mattress, pillow and the necessary coverings shall be provided for each patient. (b) There shall be a bedside table or stand and chair for each patient. (c) There shall be adequate storage space for the clothing, toilet articles and other personal belongings of patients.
Handicapped Accessible Bedroom/ Bathroom	10% (ada)	10% (ada)	10% (ada)	2.5-2.2.2		
Administrative Center/Nursing Station	Required	Required	Required	2.5-2.2.5, 2.5-2.2.6	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	Required
Staff Offices	Required	Required	Required	2.5-2.2.5, 2.5-2.2.6.3	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Administrative Supply Storage	Required. Can be part of another room.	Required. Can be part of another room.	Required. Can be part of another room.	2.5-2.2.5, 2.2..7.3	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	Required
Staff Handwash Station	Required	Required	Required	2.5-2.2.5, 2.2.6.5	These shall be conveniently accessible to the nurse station, medication station, and nourishment center. One handwashing station may serve several areas if convenient to each.	Required
Dictation Area/Charting Area	Required	Required	Required	2.5-2.2.5, 2.2.6.2	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.. May be part of another area if visual and acoustic privacy is maintained. May be combined with conference/treatment planning room.	Required
Staff Toilet Room	Required	Required	Required	2.5-2.2.5, 2.2.7.2	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	Required
Staff Lounge	Required	Required	Required	2.5-2.2.5, 2.2.7.1	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Staff Personal Belongings Storage	lockable cabinet or lockers	lockable cabinet or lockers	lockable cabinet or lockers	2.5-2.2.5, 2.2.7.3	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Soiled Workroom/Holding	Required	Required	Required	2.5-2.2.5, 2.2.6.10	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	Required
Drug Distribution Station/Medications Room	Required	Required	Required	2.5-2.2.5, 2.2.6.6	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Clean Workroom/Supply	Required	Required	Required	2.5-2.2.5, 2.2.6.9	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	Required (can combine with Clean Linen)
Clean Linen Storage	may be combined with above	may be combined in covered carts or separate storage with Clean Workroom/Supply	may be combined in covered carts or separate storage with Clean Workroom/Supply	2.5-2.2.5, 2.2.6.9	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	Required (can combine with Clean Workroom/Supply)
Kitchenette/Nourishment Station/Ice Machine	Required	Required	Required	2.5-2.2.5, 2.2.6.7	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Social/Activity Rooms 1 noisy, 1 Quiet(s.f./bed)	25 (30 sf for geriatric, 35 sf for Children) *****	25 (30 sf for geriatric, 35 sf for Children) ******	25 (30 sf for geriatric, 35 sf for Children) ******	2.5-2.2.5, 2.5-2.2.8.2	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor. Total dining plus social shall be 40 sf when same space is shared. Provide two rooms. Both of which must be at least 120 sf.	No Mention
Dining (sf/bed)	20 (15 if shared with social)	20 (15 if shared with social)	20 (15 if shared with social)	2.5-2.2.5, 2.5-2.2.8.2	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. Dining can be centralized.	No Mention

Space				Code Ref	Notes	OMH
Group Therapy	* 225 sf recommended	* 225 sf recommended	* 225 sf recommended	2.5-2.2.5, 2.5-2.2.6.15	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Patient Laundry Facility	Required	Required	Required	2.5-2.2.5, 2.5-2.2.8.3	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Secure Storage (for potentially harmful patient belongings)	for potentially harmful patient belongings	for potentially harmful patient belongings	for potentially harmful patient belongings	2.5-2.2.2	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Equipment Storage	Required	Required	Required	2.5-2.2.5, 2.5-2.2.6.11	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	Required
Wheelchair Storage	Required	Required	Required	2.5-2.2.5, 2.5-2.2.6.11	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Examination/Treatment Room	120 sf *****	120 sf *****	120 sf *****	2.5-3.1	Can serve more than one nursing unit and be located on floor separate from IPU's.	No Mention
Emergency Equipment Storage	Required	Required	Required	2.5-2.2.5, 2.5-2.2.6.11	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Housekeeping Room	Required	Required	Required	2.5-2.2.5, 2.5-2.2.6.12	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Visitors Room (s.f./bed)	100 sf. room	100 sf. room	100 sf. room	2.5-2.2.5, 2.5-2.2.8.1	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Quiet Rooms(in addition to Quiet Social/Activity above)	80 sf room ****	80 sf room ****	80 sf room ****	2.5-2.2.5, 2.5-2.2.4.4	This is different from the 120 sf small social space. Use of visitors room is permitted for this purpose if same isn't already programmed to double as consultation room.	No Mention
Consultation Rooms	1:12, 100sf min each	1:12, 100sf min each	1:12, 100sf min each	2.5-2.2.5, 2.5-2.2.6.13	Visitors room may be used as a Consult Room....but not if also doing double duty as Quiet Room. Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Staff Conference Room	may be off-unit or be combined with charting	may be off-unit or be combined with charting	may be off-unit or be combined with charting	2.5-2.2.5, 2.5-2.2.6	Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Seclusion Room	1:24 and on *each* unit, 60sf(80sf for restraint beds) room in suite with ante room and toilet. (double check total seclusion for whole hospital using the 1:24 rule) Door shall be 3'-8" minimum. H34	1:24 beds in the hospital with at least one per each nursing floor. min 60 sf for seclusion room and 80 sf for restraint. Room located in suite with ante room and toilet. (double check total seclusion for whole hospital using the 1:24 rule) Door shall be 3'-8" minimum. H34	1:24 beds in the hospital with at least one per each nursing floor. min 60 sf for seclusion room and 80 sf for restraint. Room located in suite with ante room and toilet. (double check total seclusion for whole hospital using the 1:24 rule) Door shall be 3'-8" minimum. H34	2.5-2.2.5, 2.5-2.2.4.3	Minimum 7'-0" and max 11'-0" wall length in 2006, 2010, and 2014 editions	No Mention
Isolation Room	If required by ICRA.	If required by ICRA.	If required by ICRA.	2.5-2.2..4.2	Can serve more than one nursing unit.	No Mention
Multi-Purpose Room	Required	Required	Required	2.5-2.2.5, 2.5-2.2.6.4	Can be shared by multiple units. At least one required per nursing floor.	No Mention
Patient Public Toilets	NA	NA	NA	NA		No Mention
Treatment Program/Recreation (s.f./bed)	NA	NA	NA	NA	Note that NYSCRR requirement exceeds AIA/FGI	No Mention
Classroom Space (s.f./bed) Children's Unit's Only	30	30	30		Locate in or readily accessible to each nursing unit. Can serve more than one nursing unit. At least one required on each nursing floor.	No Mention
Special Bathing Facilities	1:100 beds or fraction thereof and at least 1 bathtub on geriatric unit	1:100 beds or fraction thereof and at least 1 bathtub on geriatric unit	1:100 beds or fraction thereof and at least 1 bathtub on geriatric unit	2.5-2.2.5, 2.5-2.4.2.2		No Mention
Corridor Width	see NFPA 101	see NFPA 101	see NFPA 101	see NFPA 101		No Mention
Toilets	1 to 4	1 to 4	1 to 4	1 to 4		No Mention
Showers/Tubs	1 to 6	1 to 6	1 to 6	1 to 6		1:15 patients
Patient Bedroom Doors	3'-8" min in geriatric	3'-8" min in geriatric	3'-8" min in geriatric	3'-8" min in geriatric		No Mention
Patient Telephone	No Mention in FGI, See JCAHO Environment of Care Standards.	No Mention in FGI, See JCAHO Environment of Care Standards.	No Mention in FGI, See JCAHO Environment of Care Standards.	No Mention in FGI, See JCAHO Environment of Care Standards.		Provided
Electrical Outlets	Required in Patient Bedrooms: One on each side of the head of the bed and one on every other wall in the room.	Required in Patient Bedrooms: One on each side of the head of the bed and one on every other wall in the room.	Required in Patient Bedrooms: One on each side of the head of the bed and one on every other wall in the room.	Not mandated. If provided must be tamper resistant, ground fault protected and staff controlled by switching.		No Mention
Nurse Call						In new construction and remodeling a staff emergency call system shall be included. Call cords from wall−mounted stations of individual patient rooms may be removed when justified by psychiatric program requirements.

* to be provided but no specific space standard is stated unless it is on a unit with 12 or fewer beds and is being used to meet the Social Space requirement.
** at least one third of rooms to be provided as single
*** at least two rooms to be provided, one quiet one noisy, minimum of 120sf ea, may be combined with Dining if 15 sf added for Dining.
**** visitor room may be used for this purpose.
***** may be on a different floor or off unit
****** 35 sf in child units, 30 sf in geriatric

SOURCES:
NYCRR Title10 Health Vol. D
NYCRR Title 14 Mental Hygiene Vol. A
FGI/AIA/USDHHS Guidelines for Construction and Construction of Hospital and Health Care Facilities 1996/97, 2001, 2006, 2010
OMH Space Standards 1994

Appendix G - Benchmarking Tool and Inpatient Census Modeller

Milwaukee BHB Baseline Space Standard Modeler
96 Beds Freestanding
Logarithmic Version: November 5, 2014
Model Date 7/14/15

Total No. Inpatient Beds at Facility	96	Insert # Do not include cottage, ICF, or Residential Program Beds
FTE's (including C&Y/Forensic if served by Personnel or E&T)	240	calculated (adjust for coverage ratios different than 2.5 FTE's per b
Outpatient FTE's	0	Insert #
Research FTE's	0	Insert #
Intern Med Residents (PGME)	12	Insert #
Average Unit Size in Beds	19	Insert #
% of Beds in Private Rooms	100%	Insert #
Will Inpatient Units Have Sub-clusters?	Y	Y or N
% of Beds in Handicapped Accessible Rooms	10%	Insert #
Will Each Bedroom have a Private, Ensuite Bathroom that is not shared with Adjacent Bedrooms?	Y	Y or N
Will Inpatient Units Have 8-Foot Wide Corridors?	Y	Y or N
Number of C&Y Patients in School	18	Insert # up to maximum of 125
Number of C&Y Beds included in Total Count	18	Insert # up to maximum of 125
"Other" MCMHC & non-MCMHC	0	Insert #
OMH Adult, C&Y and Forensic BGSF	227,045	
TOTAL FACILITY GSF	**227,045**	calculated

	5% under	OMH STD	5% over	Is Service or Function Provided?	Additional Beds Supported or Not Supported by Function	Milwaukee Program
Inpatient Residential Services (INPAT)		**93,762**				**71,258**
Residential Services	48,914	51,360	53,928	Y		inc above
Adjustment for Cottage, ICF or Residential Program Beds	0	0	0	N	0	inc above
Decentralized Treatment Services	12,800	13,440	14,112	Y		inc above
Adjustment for Unit Sizes Smaller Than 30 Beds	11,582	12,161	12,769	Y		inc above
Adjustments for Private Beds in Excess of 33%	0	5,146	0	Y		inc above
Adjustment for Sub-Clusters	3,383	3,552	3,730	Y		inc above
Adjustment for Handicapped Accessible Bedrooms/Bathrooms in Excess of 10%	0	0	0	Y		inc above
Adjustment for Private, Ensuite Bathrooms not Shared with Adjacent Bedrooms	137	144	151	Y		inc above
Adjustment for 8-Foot Wide Corridors	7,581	7,960	8,358	Y		inc above
Program Space (PROGRAM)		**22,014**				**10,668**
Centralized Treatment Services	17,537	18,414	19,335	Y	0	
Adjustment for Inpatient School	2,400	2,520	2,646		0	
Adjustment for Additional Off-Unit Space Attributable to Child and Adolescent Beds	1,029	1,080	1,134		0	
Outpatient and Ambulatory Services		**0**		N		
Administration & Other		**25,328**				**17,319**
1100 Institution Direction	2,206	2,316	2,432	Y	26	
1102 Personnel	1,333	1,400	1,470	Y	26	
1103 Community Relations	181	190	200	Y	26	
1106 Information Services	1,307	1,372	1,441	Y	26	
1109 Nursing Admin.	781	820	861	Y	26	
1112 Medical Staff Admin.	429	450	473	Y	26	
1114 Social Services Staff Admin.	210	220	231	Y	26	
1116 Rehab Staff Admin.	238	250	263	Y	26	
1130 Medical Records	1,914	2,010	2,111	Y	26	
1131 Prog Eval. & Utilization Review	1,190	1,250	1,313	Y	26	
1135 EAP	190	200	210	Y		
1136 Education & Training	4,257	4,470	4,693	Y	26	
1140 Business Office	1,374	1,443	1,515	Y	26	
1141 Stores	4,608	4,838	5,080	Y	26	4,000
1161 PGME	914	960	1,008	Y		
TBD MHLS and Courtrooms/Hearing Rooms	1,190	1,250	1,313	Y		
3423 On Call Suite	286	300	315	Y	26	
NA Research		0		N		
NA Other Non-Inpatient Programs		0		N		
LOBBY Lobby Services	1,513	1,589	1,668	Y	26	
Medical Services		**22,264**				**21,235**
1144 Central Medical Supplies	1,143	1,200	1,260	Y	26	0
1152 Pharmacy	1,999	2,099	2,204	Y	26	2,194
3401 Radiology	0	0	0	N		0
3403 EEG-EKG	0	0	0	N		0
3404 Laboratory Processing	270	284	298	N	26	162
3405 Dentistry	0	0	0	N	26	0
ECT/TMS		0				0
Infection Control Nurse	171	180	189	Y		162
Employee Health Services		0		N		0
ADMISSIONS Admissions/PCS,PES,CPEP,Psych ED	17,620	18,501	19,426	Y	26	18,501
3406 Medical Clinics	0	0	0	N	26	0
3421 Physical Therapy	0	0	0	N	26	0
3422 Speech & Hearing	0	0	0	N		0
TBD Shared A & O	0	0	0	N	26	216
Support Services		**18,268**				**9,506**
1148 Nutrition Services	5,373	5,642	5,924	Y	26	3,914
1145 Housekeeping & Linen	4,050	4,252	4,465	Y	26	2,075
1104 Communications	1,062	1,115	1,171	Y	26	
1157 Safety/Security	1,883	1,977	2,076	Y	26	782
1153 Work Control/Maintenance/Shared Support	5,030	5,281	5,546	Y	26	4,924
1154 Transportation	0	0	0	N	26	
1155 Groundskeeping	0	0	0	N	26	
Total DGSF	172,987	**181,636**	190,718			**133,898**
SHRCIR Shared Circulation (3%)	5,190	5,449	5,722			
N/A Floor Plate Allowance (11%)	19,029	19,980	20,979			
1156 Utilities/Central Mech (11%)	19,029	19,980	20,979			
Total BGSF		**227,045**				**166,808**
DGSF/Bed for 96 Beds		1,892				
BGSF/Bed for 96 Beds		2,365				
DGSF/Bed for 122 Beds		1,489				
BGSF/Bed for 122 Beds		1,861				

Milwaukee County BHD

Inpatient Census Input for Hospital Modeler

architecture+ and Zimmerman Associates

Model Date   7/14/15

Model A: Nominally 144 Beds (132 Actual)

Inpatient Unit Designator	Inpatient Unit Name	Population Served/Characteristics	alos	mlos	Beds/Unit	# of Units	Total Beds
1	Acute Adult	Acute Adult	8	16	24	4	96
2	Child and Adolescent Unit	Acute Child and Adiolescent	12	24	18	1	18
3	PCS Observation Beds	72 Hour Observation Beds	3	2	18	1	18
						6	132

	Average Unit Size	22

Model B: Nominally 100 Beds (108 Actual)

Inpatient Unit Designator	Inpatient Unit Name	Population Served/Characteristics	alos	mlos	Beds/Unit	# of Units	Total Beds
1	Acute Adult	Acute Adult	8	16	24	3	72
2	Child and Adolescent Unit	Acute Child and Adiolescent	12	24	18	1	18
3	PCS Observation Beds	72 Hour Observation Beds	3	2	18	1	18
						5	108

	Average Unit Size	22

Model C: Nominally 100 Beds (96 Actual)

Inpatient Unit Designator	Inpatient Unit Name	Population Served/Characteristics	alos	mlos	Beds/Unit	# of Units	Total Beds
1	Acute Adult	Acute Adult	8	16	24	1	24
2	Acute Adult	Acute Adult	8	16	18	2	36
3	Child and Adolescent Unit	Acute Child and Adiolescent	12	24	18	1	18
4	PCS Observation Beds	72 Hour Observation Beds	3	2	18	1	18
						5	96

	Average Unit Size	19

Model D: Nominally 72 Beds (84 Actual)

Inpatient Unit Designator	Inpatient Unit Name	Population Served/Characteristics	alos	mlos	Beds/Unit	# of Units	Total Beds
1	Acute Adult	Acute Adult	8	16	24	2	48
2	Child and Adolescent Unit	Acute Child and Adiolescent	12	24	18	1	18
3	PCS Observation Beds	72 Hour Observation Beds	3	2	18	1	18
						4	84

	Average Unit Size	21

Model E: Nominally 48 Beds (48 Actual)

Inpatient Unit Designator	Inpatient Unit Name	Population Served/Characteristics	alos	mlos	Beds/Unit	# of Units	Total Beds
1	Acute Adult	Acute Adult	8	16	24	2	48
2	Child and Adolescent Unit	Acute Child and Adiolescent	12	24	18	0	0
3	PCS Observation Beds	72 Hour Observation Beds	3	2	18	0	0
						2	48

	Average Unit Size	24

Appendix H - Clinical Space (BGSF) per Bed for Similar Facilities

Peer Comparisons for Proposed Hospital
Inpatient Units and Adjuntive Therapy Spaces Only
29-Jul-15

Institution	State	Beds	Overall BGSF/Bed	Adjusted BGSF/Bed Converting to All-Private with Subclusters	Off-Unit Clinical Program DGSF/Bed	Comments
Rhode Island State Hospital (all semi-private)	Rhode Island	140	600	600	58	
Memphis Mental Health Institute	Tennessee	75	661	808	119	Acute (short stay) hospital, no subclusters, few singles
Rhode Island State Hospital (originally minimum program)	Rhode Island	140	670	670	58	.24 offices/bed if senior clinical staff elsewhere are omitted
Rhode Island State Hospital (final program)	Rhode Island	140	680	680	58	
Central Mental Health Institute	Tennessee	255	725	872	74	Acute (short stay) hospital, no subclusters, few singles
Bryce Hospital	Alabama	268	738	885	96	No subclusters, few singles.
Western Mental Health Institute	Tennessee	150	770	917	94	Acute (short stay) hospital, no subclusters, few singles
SE Indiana Training Center	Indiana	150	806	953	117	No subclusters, few singles.
Eastern Kentucky State Hospital	Kentucky	230	867	1,017	90	No subclusters, few singles.
Rochester Psychiatric Center	New York	320	982	1,132	106	No subclusters, few singles.
Proposed New Hospital, Milwaukee County	Wisconsin	122	1,025	1,025	87	96 beds plus 26 PCS Treatment Slots
Oregon State Hospital, Salem	Oregon	478	1,022	1,022	130	All-private in sub-clusters
Worcester Recovery Center and Hospital	Massachusetts	320	1,105	1,105	134	All-private in sub-clusters
Bronx Psychiatric Center (program at Master Plan)	New York	116	1,398	1,398	152	All-private in sub-clusters
Vermont Psychiatric Care Hospital	Vermont	25	1,854	1,854	415	All-private in sub-clusters

1,033 *average for all-single with subcluster*

Appendix H1 - Total Space (BGSF per Bed vs Peer Facilities)

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Name	Beds	BGSF/Bed	
Wake County Mental Health	60	923	Crisis and Rehab Services
Memphis Mental Health Institute	75	1,373	Comparable to MC-MHC
Riverview Psychiatric Hospital/AMHI *(as built)*	92	1,380	Comparable to MC-MHC
Spring Harbor Hospital	100	850	Short-term stay acute
Logansport State Hospital	126	897	Forensic
Rhode Island State Hospital,	140	764	Hotel and admin services from adjoining hospital hysical plant
Western Mental Health Institute	150	1,064	Hotel and admin services from adjoining hospital hysical plant
Kings County Phase IV	225	1,351	
Bryce Hospital, Tuscaloosa, Alabama	268	939	Hotel and admin services from adjoining hospital hysical plant
Eastern State Hospital, Kentucky	278	1,128	Comparable to MC-MHC
St. Elizabeth's	297	1,509	Comparable to MC-MHC
Massachussetts State Hospital	320	1,260	Comparable to MC-MHC
Whitby Psychiatric Center	325	1,538	Comparable to MC-MHC
Rochester Psychiatric Center	330	1,248	Comparable to MC-MHC
North Carolina State Psychiatric Hospital: Butner	429	1,080	
		1,154	**Overall Average**
		1,348	**Comparable Facility Average**

Appendix I - Space Program: Summary and Department by Department Space Lists

FULL PROGRAM

Program	96 BED HOSPITAL (plus 26 PCS)				Comments
	NSF	**Multiplier**	**Total DGSF**	**DGSF/ Bed**	
Patient Units - Mentally Ill					
Acute Adult Adult Units (One 24-Bed Unit)	10,640	1.55	16,491	687	
Acute Adult Adult Units (Two 18-Bed Units)	17,974	1.55	27,860	774	
Adolescent	11,654	1.55	18,064	1,004	
PCS	17,416	1.55	26,995	614	
Sub-Total	**57,684**		**89,410**	**733**	aggregated
Patient Therapy/Activity					
Leadership	120	1.30	156	1	
Leisure Activities	5,730	1.30	7,449	61	
Life Skills	1,010	1.30	1,313	11	
Library /Resource Center	220	1.30	286	2	
Vocational Services	0	1.30	0	0	
Public Relations/Community Educ'r	100	1.30	130	1	
Community Transition Services	0	1.30	0	0	
Volunteer Services	0	1.30	0	0	
Café	0	1.30	0	0	
Salon/Spa	0	1.30	0	0	
Shared Support	1,026	1.30	1,334	11	
Sub-Total	**8,206**		**10,668**	**87**	
Clinical Ancillaries					
Admission/Shared Support	0	1.35	0	0	
Clinic/Physician's Services	0	1.35	0	0	
Dental Clinic	0	1.35	0	0	
Radiology	0	1.35	0	0	
Lab/Phlebotomy	120	1.35	162	1	
Speech Language Services	0	1.35	0	0	
Shared Support	160	1.35	216	2	
Infection Control	120	1.35	162	1	
Pharmacy	1,625	1.35	2,194	18	
Sub-Total	**2,025**		**2,734**	**22**	
Dietary					
Kitchen/Support	3,055	1.15	3,513	29	
Office/Staff	308	1.30	400	3	
Sub-Total	**3,363**		**3,914**	**32**	
Administrative Services					
Admin/Clinical Admin	928	1.30	1,206	10	
Nursing Admin/Nursing Supervisors	248	1.30	322	3	
Human Resources/Payroll	140	1.30	182	1	
Fiscal/Accounting/Business Office	128	1.30	166	1	
Legal Affairs	1,220	1.30	1,586	13	
Lobby Services	1,496	1.30	1,945	16	
Other Shared Resources	1,162	1.30	1,511	12	
Sub-Total	**5,322**	**1.30**	**6,919**	**57**	
Information Technology & Integration					
Information Technology/MHIS	776	1.30	1,009	8	
Medical Records	0	1.30	0	0	
Quality Assur'ce/UM/Incid't Reporting	192	1.30	250	2	
Switchboard/Communications	264	1.30	343	3	

FULL PROGRAM

Program	NSF	Multiplier	Total DGSF	DGSF/ Bed	Comments
			96 BED HOSPITAL (plus 26 PCS)		
Education & Conferencing	3,241	1.30	4,213	35	
Shared Support	450	1.30	585	5	
Sub-Total	**4,923**		**6,400**	**52**	
Facilities Management					
Environmental Services	894	1.15	1,028	8	
Laundry & Linen	910	1.15	1,047	9	
Maintenance Shops	4,282	1.15	4,924	40	
Materials Management	3,478	1.15	4,000	33	
Security and Fire Safety	680	1.15	782	6	
Transportation (Bldg & Grounds)	0	1.15	0	0	
Shared Support and Locker Facilities	1,500	1.15	1,725	14	
Sub-Total	**11,744**		**13,506**	**111**	

Total Net SF (NSF)			93,267	
Total Depart Gross SF (DGSF)			133,549	
Mechanical/Electrical and Connecto	(x1.13)		17,361	
Building Gross SF on Other Progra	(x1.12)		15,463	
Total Building Gross SF (BGSF)			166,373	
Number of Patient Beds			122	**96+26 PCS**
DGSF/Bed			1,095	
BGSF/Bed			1,364	

Mental Health - Adult Units (24 beds; Each unit has 3-8 bed clusters)

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Typical Unit - 24 beds				
	Unit Space				
	Cluster A (8 Beds)				
1	Patient Room, Private	7	120	840	
2	Toilet/Shower, Patient	7	50	350	
3	Patient Room, Private HC	1	160	160	Accommodate medical beds stored elsewhere and bariatric patients.
4	Toilet/Shower, Patient HC	1	80	80	dual access from corridor and room
5	Activity/Recreation	1	240	240	
6	Visiting/Quiet/Consult Room	1	120	120	
7	Porch	0	120	0	Outdoor Space
	Subtotal			*1,790*	
	Cluster B (8 Beds)				
8	Patient Room, Private	7	120	840	
9	Toilet/Shower, Patient	7	50	350	
10	Patient Room, Private HC	1	160	160	Accommodate medical beds stored elsewhere and bariatric patients.
11	Toilet/Shower, Patient HC	1	80	80	dual access from corridor and room
12	Activity/Recreation	1	240	240	
13	Visiting/Quiet/Consult Room	1	120	120	
14	Porch	0	120	0	Outdoor Space
	Subtotal			*1,790*	
	Cluster C (8 Beds)				
15	Patient Room, Private	7	120	840	
16	Toilet/Shower, Patient	7	50	350	
17	Patient Room, Private HC	1	160	160	Accommodate medical beds stored elsewhere and bariatric patients.
18	Toilet/Shower, Patient HC	1	80	80	dual access from corridor and room
19	Activity/Recreation	1	240	240	
20	Visiting/Quiet/Consult Room	1	120	120	
21	Porch	0	120	0	Outdoor Space
	Subtotal			*1,790*	
	Care Admin/Support Cluster				
22	Exam Room	1	120	120	
23	Seclusion/Restraint Room	2	100	200	One of each
24	- Ante Room	1	60	60	
25	- Toilet	1	60	60	
26	Phone Booth	1	30	30	
27	Nursing Station	1	180	180	adj to Charting and Team Report Room, inc cubbies for patient toiletries etc
28	Charting	1	150	150	5 hoteling stations/computers @ 30 sf, an extension of the Team Conference Room
29	Team Conference/Report Room	1	225	225	up to 5 computer terminals, 8-10 and/or meeting table, locate at center care desk
30	Medication Room	1	120	120	including storage, space for 2 Pyxis machines, adj to Nursing Care Area
31	Tub Room	1	120	60	assist tub; resident/patient lift; Arjo-type tub, locate on one unit
32	Clean Utility	1	100	100	crash cart, 2 linen exchange carts
33	Soiled Utility	1	80	80	holding for soiled linen, waste
34	Patient Laundry	1	160	160	incl 1 washers, 1 dryers, sink, folding
35	Storage, Equipment	1	80	80	

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
36	Housekeeping	1	60	60	
37	Staff Lockers/Team Room	1	160	160	locate off-unit but near the unit, locked room; incl coat/boot rack, seating for 6-8, kitchenette, locker is a discrete area/alcove that doesn't overwhelm the team room
38	- Toilet, Staff	2	60	120	
39	Toilet, Visitor	1	60	60	
	Subtotal			**2,025**	

Neighborhood

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Social/Therapy Cluster				
40	Dining Room	1	600	600	may be sub-clustered to reduce noise or isolate agitated patient
41	Food Services Support Area	1	230	230	
42	Toilet, Patient	2	60	120	directly adj to Dining Area
43	Quiet Activity	1	80	80	
44	Group Therapy	2	225	450	seating for 12 - 15
45	Multi-Purpose Room	1	250	250	
46	Visitors Room/Quiet Lounge	0.67	160	107	Shared between three units
47	Comfort/Sensory Room	0.67	100	67	Shared between three units
48	Interview/Consultation Rooms	0.67	120	80	Shared between three units
49	Entrance Vestibule	1	0	0	Uses corridor space at entrance to IPU
	Subtotal			**1,985**	

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Clinical Team Cluster				
50	Office, Nurse Manager	1	140	140	
51	Office, Private	2	100	200	Psychiatrist
52	Offices, Shared (SW and OT)	4	64	256	2 per office
53	Workstation, Secretarial	1	64	64	may be combined with office equipment below
54	Workstations, Residents and Students	4	40	160	Co-locate in a single office
55	- Equipment/Files/Storage	1	100	100	incl filing allocation for itinerant clinical team members
56	Wrkstns, Rehab, MHW & Hoteling	7	40	280	for use by clinical team members, physicians, students, external agency staff while on-unit; may be grouped into offices with multiple wrkstns
57	Toilet, Staff	1	60	60	
	Subtotal			**1,260**	
	Total 26-bed Unit			**10,640**	

Department Total Net SF (NSF)		**10,640**
NSF to DGSF Multiplier		**1.55**
Departmental Gross SF (DGSF)		**16,491**

Number of Beds/Unit	24	
Number of Units	1	
Total Number of Beds	24	

TOTAL Net Area	**10,640**
TOTAL Departmental Gross Area	**16,491**

Number of Beds	**24**
DGSF	**16,491**
DGSF/Beds	**687**

Mental Health - Adult Units (2 !8 bed Units; Each unit has 2-9 bed clusters)

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments	Workstations	Offices

Typical Unit - 18 beds
Unit Space

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments	Workstations	Offices
	Cluster A (9 Beds)						
1	Patient Room, Private	8	120	960			
2	Toilet/Shower, Patient	8	50	400			
3	Patient Room, Private HC	1	160	160	Accommodate medical beds stored elsewhere and bariatric patients.		
4	Toilet/Shower, Patient HC	1	80	80	dual access from corridor and room		
5	Activity/Recreation	1	270	270			
6	Visiting/Quiet/Consult Room	1	120	120			
7	Porch	0	120	0	Outdoor Space		
	Subtotal			*1,990*			

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments	Workstations	Offices
	Cluster B (9 Beds)						
1	Patient Room, Private	8	120	960			
2	Toilet/Shower, Patient	8	50	400			
3	Patient Room, Private HC	1	160	160	Accommodate medical beds stored elsewhere and bariatric patients.		
4	Toilet/Shower, Patient HC	1	80	80	dual access from corridor and room		
5	Activity/Recreation	1	270	270			
6	Visiting/Quiet/Consult Room	1	120	120			
7	Porch	0	120	0	Outdoor Space		
	Subtotal			*1,990*			

Care Admin/Support Cluster

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments	Workstations	Offices
22	Exam Room	1	120	120			
23	Seclusion/Restraint Room	2	100	200	One of each		
24	- Ante Room	1	60	60			
25	- Toilet	1	60	60			
26	Phone Booth	1	30	30			
27	Nursing Station	1	180	180	adj to Charting and Team Report Room, inc cubbies for patient toiletries etc	2	
28	Charting	1	150	150	5 hoteling stations/computers @ 30 sf, an extension of the Team Conference Room	5	
29	Team Conference/Report Room	1	225	225	up to 5 computer terminals, 8-10 and/or meeting table, locate at center care desk	5	
30	Medication Room	1	120	120	including storage, space for 2 Pyxis machines, adj to Nursing Care Area		
31	Tub Room	1	120	60	assist tub; resident/patient lift; Arjo-type tub, locate on one unit		
32	Clean Utility	1	100	100	crash cart, 2 linen exchange carts		
33	Soiled Utility	1	80	80	holding for soiled linen, waste		
34	Patient Laundry	1	160	160	incl 1 washers, 1 dryers, sink, folding		
35	Storage, Equipment	1	80	80			
36	Housekeeping	1	60	60			
37	Staff Lockers/Team Room	1	160	160	locate off-unit but near the unit, locked room; incl coat/boot rack, seating for 6-8, kitchenette, locker is a discrete area/alcove that doesn't overwhelm the team room		
38	- Toilet, Staff	2	60	120			
39	Toilet, Visitor	1	60	60			
	Subtotal			*2,025*			

Neighborhood

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments	Workstations	Offices
	Social/Therapy Cluster						
40	Dining Room	1	450	450	may be sub-clustered to reduce noise or isolate agitated patient		
41	Food Services Support Area	1	230	230			
42	Toilet, Patient	2	60	120	directly adj to Dining Area		
43	Quiet Activity	1	80	80			
44	Group Therapy	1.5	225	338	505 of total allocation, shared in neighborhood). seating for 12 - 15		

45	Multi-Purpose Room	1	250	250	incl storage cupboards for therapies including musical instruments CAN THIS BE USED FOR FAMILY CONSULT?			
46	Visitors Room/Quiet Lounge	0.67	160	107	Shared between three units			
47	Comfort/Sensory Room	0.67	100	67	Shared between three units			
48	Interview/Consultation Rooms	0.67	120	80	Shared between three units			
49	Entrance Vestibule	1	0	0	Uses corridor space at entrance to IPU			
	Subtotal			*1,722*				

Clinical Team Cluster

50	Office, Nurse Manager	1	140	140				1
51	Office, Private	2	100	200	Psychiatrist			2
52	Offices, Shared (SW and OT)	4	64	256	2 per office		4	
53	Workstation, Secretarial	1	64	64	may be combined with office equipment below		1	
54	Workstations, Residents and Students	4	40	160	Co-locate in a single office		4	
55	- Equipment/Files/Storage	1	100	100	incl filing allocation for itinerant clinical team members			
56	Wrkstns, Rehab, MHW & Hoteling	7	40	280	for use by clinical team members, physicians, students, external agency staff while on-unit; may be grouped into offices with multiple wrkstns		7	
57	Toilet, Staff	1	60	60			28	3
	Subtotal			*1,260*				
	Total 26-bed Unit			**8,987**				

Department Total Net SF (NSF)	**8,987**	
NSF to DGSF Multiplier	**1.55**	
Departmental Gross SF (DGSF)	**13,930**	

Number of Beds/Unit	**18**	
Number of Units	**2**	
Total Number of Beds	**36**	

TOTAL Net Area	**17,974**
TOTAL Departmental Gross Area	**27,860**

Number of Beds	**36**
DGSF	**27,860**
DGSF/Beds	**774**

Mental Health t Adolescent Units (18 beds Each unit as 3 paired 6 bed clusters)

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Unit Space				
	Cluster 1-A 1 (6 Beds)				
1	Patient Room, Private	6	120	720	
2	Toilet/Shower, Patient	6	50	300	accessible from a corridor alcove
3	Patient Room, Private HC	0	180	0	can be used as a double room
4	Toilet/Shower, Patient HC	0	80	0	accessible from a corridor alcove
5	Activity/Recreation, Large	1	240	240	
6	Visiting/Quiet/Consult Room	1	140	140	
7	Porch	0.3	280	0	Outdoor Space. Shared between three clusters
8	Comfort Room	1	100	100	
	Subtotal			**1,500**	
	Cluster 1-A 1 (6 Beds)				
9	Patient Room, Private	5	120	600	
10	Toilet/Shower, Patient	5	50	250	accessible from a corridor alcove
11	Patient Room, Private HC	1	180	180	can be used as a double room
12	Toilet/Shower, Patient HC	1	80	80	accessible from a corridor alcove
13	Activity/Recreation, Large	1	240	240	
14	Visiting/Quiet/Consult Room	1	140	140	
15	Porch	0.3	280	0	Outdoor Space. Shared between three clusters
16	Comfort Room	1	100	100	
	Subtotal			**1,590**	
	Cluster 1-A 1 (6 Beds)				
17	Patient Room, Private	5	120	600	
18	Toilet/Shower, Patient	5	50	250	accessible from a corridor alcove
19	Patient Room, Private HC	1	180	180	can be used as a double room
20	Toilet/Shower, Patient HC	1	80	80	accessible from a corridor alcove
21	Activity/Recreation, Large	1	240	240	
22	Visiting/Quiet/Consult Room	1	140	140	
23	Porch	0.3	280	0	Outdoor Space. Shared between three clusters
24	Comfort Room	1	100	100	
	Subtotal			**1,590**	
	Support Zone (18 beds)				
25	Care Station	1	180	180	adj to Charting and Team Report Room and cubbies for patient toiletries, etc
26	Treatment Planning/Chart Area	1	150	150	5 hoteling stations/computers @ 30 sf, an extension of the Team Conference Room
27	Team Conference/Report	1	225	225	up to 5 computer terminals, 8-10 and/or meeting table, locate at center care desk
28	Medication Room	1	120	120	including storage, space for 2 Pyxis machines, adj to Nursing Care Area
29	Exam Room	1	120	120	
30	Seclusion/Restraint Room	2	100	200	
31	- Ante Room	1	60	60	
32	- Toilet, Seclusion Room	1	60	60	
33	Dining Room	1	450	450	
34	- Toilet	1	60	60	
35	Dining Support Pantry/Servery	1	230	230	
36	Clean Utility	1	80	80	crash cart, 2 linen exchange carts
37	Soiled Utility	1	80	80	holding for soiled linen, waste
38	Patient Laundry	1	120	120	incl washer, dryer, sink, folding, dual access
39	Storage, Equipment	1	80	80	
40	Housekeeping	1	60	60	

41	Staff Lockers/Team Room	1	120	120	locked room; incl coat/boot rack, seating for 4, kitchenette
42	- Toilet, Staff	2	60	120	
43	Toilet, Visitor	1	60	60	
44	Office, Nurse Manager	1	100	100	
45	Office, Private	4	100	400	Clinical Director, psychiatrists
46	Office, Shared	3	140	420	may be used by physicians/psychiatrists, social work, psychology, others who need confidential environment; some may be set-up with 2 workstations
47	Workstations, Residents and Students	4	40	160	Co-locate in a single office
48	Workstation, Secretarial	1	64	64	may be combined with office equipment below
49	- Equipment/Files/Storage	1	200	200	incl filing allocation for itinerant clinical team members; incl additional allocation as this program may not be using electronic client records
50	Toilet, Staff	1	60	60	
	Subtotal			*3,979*	

Neighborhood (Supports 18)

	Social/Therapy Cluster				
51	Toilet, Patient	2	60	120	
52	Quiet Activity	1	150	150	
53	Visiting	2	140	280	
54	Group Therapy	2	225	450	seating for 12 - 15
55	Multi-Purpose Room	1	375	375	incl storage cupboards for use by therapists
56	Interview/Consultation Rooms	1	120	120	
57	Entrance Vestibule	0	80	0	
58	Porch/Patio	1	0	0	Outdoor porch or patio will be required (300sf); excluded from space list as it is not a building area
	Subtotal			*1,495*	

Department Total Net SF (NSF)   10,154
NSF to DGSF Multiplier   1.55
Departmental Gross SF (DGSF)   15,739

SHARED THERAPY/ACTIVITY SPACE   *Located between Neighborhood & School*

59	Exercise Room	1	600	600	Weights and Fitness machines; up to 12 adolescents at a time
	Subtotal			*600*	

SCHOOL PROGRAM
Education Cluster - Adolescents

60	General Classrooms	2	200	400	
61	Multi-purpose Classroom	1	200	200	
62	Toilet, Staff	1	60	60	
63	Toilets (Male & Female)	0	120	0	See above
64	Professional Development	1	240	240	serves also as Staff Room
	Subtotal			*900*	

Department Total Net SF (NSF)   1,500
NSF to DGSF Multiplier   1.55
Departmental Gross SF (DGSF)   2,325

GRAND TOTAL   18,064 DGSF

Outdoor Spaces/Access
Every house needs access to a secure courtyard and to a porch

Mental Health - Adolescent Units (19 b

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
1	**Intake**				
1.1	Vehicle Sallyport: Admissions	1	500	500	Locate at Admissions. Make sure bay is large enough to accommodate an ambulance. Provide a gun locker.
1.2	Family Lockers	1	60	60	10 lockers, plus 2 gun lockers at entry
1.3	Entrance Vestibule	2	80	160	leave room for metal detector
1.4	Security Control/Reception/ Triage	1	450	450	3 officers plus patient, transport and a nurse a CNA and registration
1.5	Waiting-Adults	1	450	450	Inside secure perimeter, 20 chairs comfortably,
1.6	Waiting - Child & Adolescent	1	440	440	Inside secure perimeter, 10 chairs
1.7	Holding - Secure	1	150	150	Patients will stay in EMS or police vehicle until PCS is ready to triage.
1.8	Patient Toilet	2	40	80	Provide 1 HC and 1 regular unisex toilet at each of the two waiting areas.
1.9	Patient Toilet (HC)	2	60	120	Provide 1 HC and 1 regular unisex toilet at each of the two waiting areas.
1.10	Shower	1	60	60	In safety corridor at triage
1.11	Stretcher/Wheelchair Storage	1	100	100	
	Subtotal			*2,570*	

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
2	**Shared Clinical/Intake Assessment**				
2.1	Interview/Consultation Room (Individual)	4	120	480	
2.2	Consultation Room (Family)	1	180	180	6 people
2.3	Exam Room	1	130	130	
2.4	Office, Transfer Coordinator	1	100	100	
2.5	Property Holding	1	225	225	
	Subtotal			*1,115*	

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
3	**Children & Adolescents Treatment/Observation**				
3.1	Exam Room	0	130	0	See Shared Clinical
3.2	Interview/Consultation Room (Individual)	0	120	0	See Shared Clinical
3.3	Observation Bedrooms/Seclusion	1	120	120	
3.4	Observation Bedrooms/Seclusion Ante R	1	80	80	
3.5	Bathroom for Observation Bedrooms	1	60	60	
3.6	Observation Bays (Curtained)	0	100	0	see Activity Room (below)
3.7	Activity Room	1	480	480	5 to six kids in chairs and couches (meets 6 bay at 80 sf requirement
3.8	Nurse Station	0	0	0	Shared with Adult Treatment
3.9	Patient Toilet	1	60	60	Handicapped accessible
3.10	Patient Toilet	1	40	40	
3.11	Patient Shower	0	60	0	
3.12	Clean Supply Room	0	100	0	Shared with Adult Treatment
3.13	Soiled Work Room	0	100	0	Shared with Adult Treatment
	Subtotal			*840*	

4   Adult PCS

4.1	Observation Room	1	2,400	2,560	20 patient recliners at 80 sf each plus central space. Arrange into a minimum of four alcove groupings
4.2	Activity Room	1	400	400	40 sf each for 10 occupants. Can double as observation for 5 additional patients.
4.3	Exam Room	1	120	120	
4.4	Comfort Room	4	100	400	
4.5	Interview/Consultation Cubicle (Individua	2	100	200	
4.6	Close Observation/Seclusion Rooms	2	120	240	Locate in zone independently accessible from both PCS and Ambulance Entry.
4.6a	Observation Bedrooms/Seclusion Antero	1	50	50	
4.6b	Observation Bedrooms/Seclusion Toilet	1	40	40	
4.7	Shower Rooms	2	64	128	
4.8	Patient Toilet	2	50	100	
4.9	Patient Toilet (HC)	2	60	120	
4.10	Staff Toilet	1	40	40	
4.11	Staff Toilet (HC)	1	60	60	
4.12	Nourishment	1	80	80	
4.13	Nursing Station/Care Desk	1	624	624	accommodate 13 staff
4.14	Clean Supply Room	1	100	100	
4.16	Soiled Work Room	1	120	120	
4.17	Medication Room	1	120	120	
4.18	Nurse Manager's Office	1	100	100	
4.19	Nurse Supervisor Office	1	100	100	
4.2	Physician's Office (Workstations)	5	40	200	
4.21	Social Workers' Office/Homebase (works	3	48	144	
4.21	Post Graduate Medical Education	6	40	240	
4.22	Staff Break Room/Locker Room	1	300	300	Accommodate 5 staff.
4.23	General Storage	2	100	200	
4.24	Housekeeping	1	60	60	
	Subtotal			*6,846*	

5 **Adult Extended Observation Suite**

5.1	Observation Beds	16	120	1,920	
5.2	Extended Observation Beds (HC)	2	160	320	Equip both as infection control isolation rooms.
5.3	EOB Toilets	16	40	640	
5.4	EOB Toilets (HC)	2	60	120	
5.5	EOB Activity Therapy	1	540	540	
5.6	EOB Dining	1	450	450	
5.7	EOB Pantry	1	230	230	
5.8	Quiet Activity Room	1	120	120	
5.9	Visiting Room/Quiet Activity	2	120	240	
5.10	Consult	2	120	240	
5.11	EOB Nursing Station	1	360	360	
5.12	Clean Supply Room	1	100	100	
5.13	Soiled Work Room	1	100	100	
5.14	Laundry	1	100	100	
	Subtotal			*5,480*	

6 **Administrative Support**

6.1	Office - Medical Director/Unit Manager	2	120	240	
6.2	Clinician's Office	1	100	100	Shared between shifts
6.3	Conference Room/Team Room	1	225	225	Share with Obs
	Subtotal			*565*	

Total Net Area	**17,416**
NSF to DGSF Multiplier	**1.55**
Total Departmental Gross Area	**26,995**

Patient Therapy/Activity

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Leadership				
1	Rehab Services Supervisor	1	120	120	See Administration
	Subtotal			*120*	
	Leisure Activities				
2	Gymnasium/Multi-Purpose Room	1	3,600	3,600	Half court
3	Storage, Gym Equipment	1	150	150	
4	Exercise/Fitness Room	1	600	600	*6 stations (treadmills, bikes, weights, etc)*
5	Movement Studio	1	600	600	*for movement classes, yoga, etc.; outfitted with wall-mirrors (non-breakable), adjacent storage for musical instruments*
6	Physiotherapy Room	0	400	0	Utilize bedside, on-unit multi purpose room, Movement Room or Art Therapy Room
7	Storage, Equipment	1	150	150	Storage adjacent to Movement, store cart, chairs and instruments
8	Music Therapy Room	0	400	0	Shared with movement.
9	Chapel	1	450	450	aka Spirituality Center. Seating for 30. Nearby Meditation Garden. Provide Monarch Watch Waystation Display in adjacent corridor.
10	Storage, Chapel/Chaplain	1	40	40	
11	Office, Chaplain	1	140	140	Shared by Chaplains (one .75 FTE plus three visiting chaplains = 2 total w.s.)
	Subtotal			*5,730*	
	Life Skills				
12	Arts Room	1	400	400	10 people
13	Greenhouse	1	250	250	
14	ADL-Teaching Kitchen/Laundry	1	200	200	in addition to apartments in Patient Care Units
15	Storage, Equipment	1	80	80	
16	Storage, Materials	1	80	80	
	Subtotal			*1,010*	
	Library/Resource Center				adj to Voc'l Services, below
17	Library/Computer Resources	1	220	220	2 computers, a worktable and a small book collection. Space for mobile book cart.
	Subtotal			*220*	
	Vocational Services				
	None	0	40	0	
	Subtotal			*0*	
	Public Relations, Peer Services, Community Educator				
18	Office, Staff	1	100	100	aka Consumer Affairs Coordinator
	Subtotal			*100*	
	Community Transition Services				
	None	0	40	0	accommodated on IPU's
	Subtotal			*0*	
	Volunteer Services				
	None	0.0	120	0	None Needed
	Subtotal			*0*	
	Café				
	None	0	360	0	

	Subtotal			*0*	

Salon/Spa

	None	0	20	0	
	Subtotal			*0*	

Shared Support and Staffing

19	Music Therapist Workstation	2	64	128	
20	OT Workstation	7	64	448	
21	Housekeeping	1	60	60	
22	Staff Toilets	2	60	120	
23	Patient/Visitor Toilets	2	60	120	
24	Copy Rooms, Supplies	1	150	150	
	Subtotal			*1,026*	

Department Total Net SF (NSF)	**8,206**
NSF to DGSF Multiplier	**1.30**
Departmental Gross SF (DGSF)	**10,668**

Number of Key Rooms	**31**
DGSF	**10,668**
DGSF/Key Room	**344**

Number of Beds	**96**
DGSF	**10,668**
DGSF/Bed	**111**

Ancillaries - Clinical

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Reception/Registration				
	None	0	150	0	
	Subtotal			*0*	
	Clinic				
	None	0	140	0	
	Subtotal			*0*	
	Dental Clinic				
	None	0	120	0	
	Subtotal			*0*	
	Radiology				
	None	0	360	0	
	Subtotal			*0*	
	Laboratory				
1	Phlebotomy	0	80	0	Draw in exam rooms on unit or in PCS
2	Laboratory	1	120	120	Refrigerator, work counter, storage (specimen tubes, etc)
	Subtotal			*120*	
	Speech Language Services				
	None	0	160	0	
	Subtotal			*0*	
	Pharmacy				
3	Waiting	1	40	40	Adjacent to pickup counter
4	Consult/ Space	1	100	100	1 on 1 Counseling
5	Pick-up Counter	1	40	40	at edge of main pharmacy room
6	Dispensing Area	1	40	40	at edge of main pharmacy room
7	Cart Holding	1	30	30	carts for transporting meds to Care Units; assume 3 carts to be held, in main pharmacy room
8	Picking Area, Compounding, Unit Dosing, Bulk Storage and Receiving	1	750	750	Incl. Computers and Sink, open shelving in main pharmacy room
9	Vault, narcotics	1	25	25	Pyxis vault and refrigerator, maybe 2 towers
	Office Area				
10	Office, Pharmacist	2	100	200	
11	Workstations, Pharmacists	4	64	256	locate in ED
12	Workstations, Pharmacy Tech	3	48	144	
	Subtotal			*1,625*	
	Infection Control				
13	Office, RN	1	120	120	Individual sessions; most will occur on-unit
	Subtotal			*120*	
	Shared Support				
14	On-Call Room	1	100	100	
15	On-Call Toilet	1	60	60	3-piece
	Subtotal			*160*	

Department Total Net SF (NSF)	**2,025**
NSF to DGSF Multiplier	**1.35**
Departmental Gross SF (DGSF)	**2,734**

architecture+/Zimmerman Architectural Studios

Ancillaries - Clinical

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Number of Key Rooms			**20**	
	DGSF			**2,734**	
	DGSF/Key Room			**137**	
	Number of Beds			**122**	
	DGSF			**2,734**	
	DGSF/Bed			**22**	

Dietary Support

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Kitchen/Support				
1	Receiving	1	150	150	
2	Dry Storage	1	250	250	
3	Walk-in Cooler	1	200	200	dairy, meat, vegetables
4	Walk-in Freezer	1	150	150	meat, vegetables
5	Cooler - Prepared Foods	1	200	200	
6	Cooking/Prep Area	1	800	800	
7	Trayline/portioning	1	425	425	
8	Docking - Food Service Carts	1	120	120	to accommodate carts for 4 Pt Care Units
9	Dishwashing/Pot Wash	1	240	240	
10	Cart Marshalling	1	80	80	for carts returning from units
11	Waste Collection/Holding	1	120	120	refrigerated
12	Cart Wash Room	1	120	120	manual system
13	Housekeeping Closet	1	60	60	
14	Lockers	0	80	0	Included in Facilities Management
15	Restroom/Lunchroom	0	180	0	Included in Facilities Management. Location convenient to kitchen is required by WIS 124.16(e)
16	Misc. Storage (Trays, Flatware)	1	140	140	
	Subtotal			**3,055**	
	DGSF Factor			**1.15**	
	Total			**3,513**	

Office/Staff

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
17	Dietary Manager	1	100	100	
18	Diet Clerks	1	64	64	all wrkstns in 1 office
19	Clin. Dietician	1	80	80	all wrkstns in 1 office
20	Head Cook/Cooks	1	64	64	all wrkstns in 1 office
	Subtotal			*308*	
	DGSF Factor			*1.30*	
	Total			*400*	

Department Total Net SF (NSF)		3,363
Departmental Gross SF (DGSF)		3,914

Number of Key Rooms	18
DGSF	3,914
DGSF/Key Room	217

Number of Beds	122
DGSF	3,914
DGSF/Bed	32

Administrative Services

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Hospital Administration				
1	Waiting	1	160	160	
2	Wrkstn, Admin Ass't/Clerk	1	64	64	
3	Office, Executive Director	1	180	180	
4	Office, Director of Support Services	1	180	180	
	Subtotal			**584**	
	Clinical Administration				
5	Office, Medical Director/CMO	1	180	180	
6	Workstation, Admin Assist	1	64	64	
7	Office, Clinical Directors	0	120	0	All on-unit
8	- Storage, Supplies/Files	1	100	100	
	Subtotal			**344**	
	Nursing Administration				
9	Office, Director of Nursing/CNO	1	120	120	
10	Staffing Office Workstation, Clerk	1	64	64	
	Subtotal			**184**	
	Nursing Supervisors				
11	Off Shift Supervision	1	64	64	
	Subtotal			**64**	
	Human Resources/Payroll				
12	Waiting	0	100	0	Shared with other Admin Functions
13	Offices	1	140	140	w/ meeting space for 4
	Subtotal			**140**	
	Fiscal/Accounting/Business Office				
14	Workstation, Staff	2	64	128	Ordering Supplies
	Subtotal			**128**	
	Legal Affairs				
15	Office, County Attorney's	1	100	100	
16	Consultation Room	1	120	120	
17	Court Room	2	320	640	seats 10-12
18	Police Waiting Room	1	120	120	
19	Waiting Room	2	120	240	each seats 8-10
	Subtotal			**1,220**	
	Lobby Services				
20	Lobby Waiting	1	180	180	Seats 12
21	Visitors Lockers	1	120	120	Also include space for gun locker.
22	Visitor's Lounge/Consult	1	100	100	
23	Visitor Toilets	2	120	240	multi-stall
24	Information Desk/Walk-in Patient Access D	1	80	80	Safety Officer staffed. No registration function.
25	Offices	3	100	300	Consumer affairs/patient rights, Medical Record Release, Financial Counselor/Eligibility
26	Warm Handoff Room	1	160	160	Space for community partners come in who provide care in the outpatient arena and help patients who are leaving get connected to outside programs. Accommodates 3-5 patients and staff at one time.
27	Transition of Care/Community Services Wo	2	48	96	Hoteling for community providers. 2 workstations

Administrative Services

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
28	Main Entrance Sallyport	1	60	60	
29	Staff Sallyport	1	40	40	
30	Visitor Toilets	2	60	120	
	Subtotal			**1,496**	

Shared Resources

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
31	Storage, Photocopy and Filing	1	150	150	
32	Hoteling Workstations	4	48	192	Visiting Staff of 'Integrated Functions' from off-site
33	Conference Room (Small)	1	180	180	seats 8 - 10
34	Conference Room (Medium)	1	280	280	seats 14 - 16; see also Information Technology & Integration; incl integrated conferencing
35	Conference Room (Large)	0			see Information Technology & Integration for Multi-purpose Training Room
36	Toilet, Staff	3	60	180	
37	Kitchenette/Break Room	1	120	120	
38	Housekeeping	1	60	60	
	Subtotal			**1,162**	

Department Total Net SF (NSF)	**5,322**
NSF to DGSF Multiplier	**1.30**
Departmental Gross SF (DGSF)	**6,919**

Number of Key Rooms	**48**
DGSF	**6,919**
DGSF/Key Room	**144**

Number of Beds	**122**
DGSF	**6,919**
DGSF/Bed	**57**

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Information Technology/MHIS				
1	Server Room	1	180	180	
2	Work Room	1	160	160	may be integrated with staff workstations
4	Peripheral/Parts Storage	1	180	180	
5	Data Closets				incl in Building Gross Area Allocation as an allowance
6	Workstations ,IT and Telephony Staff	2	64	128	
7	Workstation, EMR Support Staff	2	64	128	
	Subtotal			*776*	
	Medical Records				
8	Workstation, MR Clerks	0	64	0	Records Request. Locate proximate to entrance. See Lobby Services
	Subtotal			*0*	
	Quality Assur/Utliz'n Review//Incident Reporting				
9	Case Management (UR,QA,Discharge P	3	64	192	Mix of RN's and SW's
	Subtotal			*192*	
	Switchboard/Telecom Center/Reception				
10	Comm Dispatch Wkstn	1	64	64	
11	Wrkstns-Phone Communic'n/ Emergency Phone	0	100	0	See Security program
12	Mail Sorting	1	120	120	
13	Storage/Files	1	80	80	
	Subtotal			*264*	
	Education & Conferencing				
14	Office, Director	1	120	120	
15	Workstation, Staff	4	64	256	
16	Pre-function and Break Area	1	250	250	
17	Training Room, Large	1	900	900	Subdivide-able into two rooms
18	Catering Kitchen	1	120	120	
19	CPR/Restraints Room	1	375	375	show typical bed/bath module in flooring within the room
20	AV Storage	1	60	60	secure; accessible from each of the 2 training rooms and 2 meeting rooms
21	Computer Training Lab	1	650	650	25 computer training stations; room may be located decentrally in order to be more conveniently located to hospital staff
22	Copier and Storage, Supplies	1	150	150	extra chairs on dollies, portable dais, etc.
23	Toilets, Male	3	60	180	
24	Toilets, Female	3	60	180	
	Subtotal			*3,241*	
	Shared Support				
25	Housekeeping	1	60	60	
26	Toilets, Staff	2	60	240	
27	Staff Break Room	1	150	150	
	Subtotal			*450*	

Department Total Net SF (NSF)   4,923
NSF to DGSF Multiplier   1.30

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Departmental Gross SF (DGSF)			**6,400**	
	Number of Key Rooms			**35**	
	DGSF			**6,400**	
	DGSF/Key Room			**183**	
	Number of Beds			**122**	
	DGSF			**6,400**	
	DGSF/Bed			**52**	

Support Services - Facilities Management

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Environmental Services				
1	Office, Manager	2	100	200	County Contract Manager and Vendor Site Manager
2	Wrkstn, Staff Supervisor	1	64	64	
3	Storage, Files	1	40	40	
4	Storage, Bulk Supply	1	200	200	Cleaning Supplies. Weekly supplies.
5	Storage, Cleaning Equipment	1	150	150	rooms located centrally for larger pieces of equipment (scrubbers, burnishers, etc.)
6	Wheelchair Cleaning	1	140	140	Floor drain, exhaust
7	Washer/Dryer for Mop Heads	1	100	100	
8	Decentralized Housekeeping Closets	0	0	0	(See individual Departmental Space Programs for NSF) floor sink, utility sink, supplies, mops, cleaner's carts, etc.
	Subtotal			*894*	

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Laundry/Linen				
9	Clean Holding Room	1	240	240	6 exchange carts, 4 small clothing carts and maneuvering space (delivered 3x per week to hospital) Refill for floor every day
10	Back-up Stock Room	1	100	100	
11	Sorting Room	1	180	180	
12	Specialty Laundering	1	150	150	Semi-commercial washer & dryer
13	Soiled Holding Room	1	240	240	6 carts, cool and vent
	Subtotal			*910*	

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Physical Plant/Maintenance				
14	Office, Director	1	100	100	
15	Workstation, Clerical	1	64	64	
16	Storage/Equipment	1	100	100	may be combined with clerical above
17	Hoteling Workstations	1	40	40	Contractors, staff, others
18	Workstation, Foreman/Suprvrs	2	64	128	
19	General Shop	1	2,750	2,750	overhead lift (manual); combination of work benches and open floor space; safe clearances around equipment; in-shop storage for tools, small supplies/parts
20	Carpentry Alcove	1	200	200	Area part of general shop
21	Plumbing Alcove	1	200	200	Area part of general shop
22	Electrical Alcove	1	200	200	Area part of general shop
23	Locksmith Alcove	1	100	100	Area part of general shop
24	Bulk Storage, Maint. Supply	1	400	400	JIT Inventory
	Subtotal			*4,282*	

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Materials Management				
25	Office, Supervisor	1	100	100	
26	Loading Dock	1	800	800	Incl 2 Dock Areas
27	Workstation, Distribution and Clerical	2	64	128	at Receiving
28	Secured Holding	0	180	0	Lockable, for received goods going to other departments
29	Product Marshaling	1	150	150	hold Product checked and ready for transport to user location
30	Bulk Storage Warehouse	1	1,200	1,200	incl consumables, furniture, computers and printers, etc.; secure cage system for some categories

Support Services - Facilities Management

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
31	Bulk Storage, Central Med Supply	1	200	200	for product requiring secure and separate holding (e.g. sterile product); add'l medical supplies incl above
32	Patient Storage	1	200	200	Limit to five boxes per patient; approx 280 patients; stacking system for 4 - 5 boxes high
33	Emergency Preparedness Supplies	0	600	0	incl 300 cots, dehydrated food, water, etc (72 hours supply).
34	Backup Stock: Furniture, Mattresses, Wheelchairs	1	400	400	
35	Oxygen Storage	1	40	40	3-4 H tanks, 30-40 e-tanks, enclosed room on external wall
36	Trash Compactor	0	100	0	outside the building at the dock area
37	Recycling Center	0	300	0	outside the building at the dock area
38	Biohazard Waste Holding	1	60	60	refrigerated
39	Kitchen Waste	0	60	0	See kitchen program
40	Holding for Disposal	1	200	200	furniture, computers, etc.
	Subtotal			*3,478*	

Security and Safety

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
41	Office, Security Chief	1	100	100	
42	Office, Chief Safety Officer	1	100	100	
43	Reception, Sallyport				See Lobby Services
44	Control Center/General Office	1	120	120	1 wrkstn @ 64 sf plus control panels, monitoring screens
45	Recording/Tape Review/Report	1	180	180	Include employee ID
46	Toilet, Staff	1	60	60	
47	Lockers, Staff (Male & Female)	2	60	120	5 lockers in each room, storage of uniforms, supplies, etc.
48	Emergency Preparedness Supplies	0		0	see Materials Management above
	Subtotal			*680*	

Transportation and Grounds

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
49	Supervisor's Workstation	0	80	0	Contracted or by County
50	Workstation, Clerical	0	64	0	incl monitoring/supporting computerized scheduling of maintenance requests, etc.
51	Storage	0	400	0	Contracted or by County
52	Garage Service Bays	0	0	0	County Garage
53	Grounds Equipment Staging & Repair	0	750	0	Contracted or by County. May be taken over by Hospital. storage of equipment will occur in out-building (approx 750 SF)
54	Gas/Diesel Pumps	0	0	0	County Garage
55	Dispatch/Drivers Wait Area	0	150	0	Contracted Service
	Subtotal			*0*	

Shared Support and Employee Locker/Restroom

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
56	Breakroom, Staff	1	250	250	Share with Mat Mgmt, Dietary& Physical Plant; kitchenette, seating for 8 - 10
57	Copiers and Office Supplies	1	150	150	
58	Housekeeping	2	60	120	
59	Toilet, Staff	4	60	240	
60	Locker Rooms (Male, Female)	2	250	500	75 lockers total between 2 rooms
61	- Toilet/Shower, Staff	2	120	240	
	Subtotal			*1,500*	

Support Services - Facilities Management

Ref	Program Spaces	No. of Spaces	NSF/ Space	Total NSF	Comments
	Department Total Net SF (NSF)			**11,744**	
	NSF to DGSF Multiplier			**1.15**	
	Departmental Gross SF (DGSF)			**13,506**	
	Number of Key Rooms			**56**	
	DGSF			**13,506**	
	DGSF/Key Room			**241**	
	Number of Beds			**122**	
	DGSF			**13,506**	
	DGSF/Bed			**111**	

Appendix J - Staffing Projection and Staff Workstations in Program

Benchmark Staffing Plan and Office Workstation Needs
New Hospital: Milwaukee County Behavioral Health Board
6/12/15

ZIMMERMAN ARCHITECTURAL STUDIOS, INC. — architecture+

	Paid FTEs	Headcount Factor	# Individuals Trained	Anticipated Requirement Workstations	Anticipated Requirement Offices	Per Space Program Workstations	Per Space Program Offices
Adolescent Unit Unit						21	4
Staff RN	14.74	1.26	18.63	4			
MHT	14.74	1.26	18.63	1			
Manager	1.00	1.26	1.26		1		
RN Supervisor	0.59	1.26	0.74		1		
Rec /Occp Therapist	2.34	1.26	2.96	2			
Education Specialist	1.00	1.26	1.26	1			
RN Case Manager	1.00	1.26	1.26	1			
Clerical	1.64	1.26	2.07	1			
Social Worker	4.68	1.26	5.91	3			
Psychiatrist	3.00	1.67	5.00	2			
Nurse Practitioner	1.60	1.67	2.67	1			
18 Bed Observation Unit						see PCS	see PCS
Staff RN	16.38	1.26	20.70	6			
MHT	4.91	1.26	6.21	1			
Manager	0.50	1.26	0.63		0.5		
RN Supervisor	0.59	1.26	0.74		0.5		
Rec /Occp Therapist	1.76	1.26	2.22	0.5			
Education Specialist	0.00	1.26	0.00				
RN Case Manager	0.50	1.26	0.63	0.5			
Clerical	1.64	1.26	2.07	1			
Social Worker	2.34	1.26	2.96	2			
Psychiatrist	1.20	1.67	2.00		1		
Nurse Practitioner	1.20	1.67	2.00		1		
24 Bed Adult (Unit I)						28	3
Staff RN	18.84	1.26	23.80	5			
MHT	8.19	1.26	10.35	1			
Manager	0.50	1.26	0.63		0.5		
RN Supervisor	0.59	1.26	0.74		0.5		
Rec /Occp Therapist	1.76	1.26	2.22	0.5			
Education Specialist	0.00	1.26	0.00				
RN Case Manager	0.50	1.26	0.63	0.5			
Clerical	1.64	1.26	2.07	1			
Social Worker	3.51	1.26	4.44	3			
Psychiatrist	2.40	1.67	4.00		2		
Nurse Practitioner	0.00	1.67	0.00				
18 Bed Adult (Unit II)						28	3
Staff RN	16.38	1.26	20.70	5			
MHT	4.91	1.26	6.21	1			
Manager	0.50	1.26	0.63		0.5		
RN Supervisor	0.59	1.26	0.74		0.5		
Rec /Occp Therapist	1.76	1.26	2.22	0.5			
Education Specialist	0.00	1.26	0.00				
RN Case Manager	0.50	1.26	0.63	0.5			
Clerical	1.64	1.26	2.07	1			
Social Worker	2.34	1.26	2.96	3			
Psychiatrist	1.20	1.67	2.00		2		
Nurse Practitioner	1.20	1.67	2.00				
18 Bed Adult (Unit III)						28	3
Staff RN	16.38	1.26	20.70	5			
MHT	4.91	1.26	6.21	1			
Manager	0.50	1.26	0.63		0.5		
RN Supervisor	0.59	1.26	0.74		0.5		
Rec /Occp Therapist	1.76	1.26	2.22	0.5			
Education Specialist	0.00	1.26	0.00				
RN Case Manager	0.50	1.26	0.63	0.5			
Clerical	1.64	1.26	2.07	1			
Social Worker	2.34	1.26	2.96	3			
Psychiatrist	1.20	1.67	2.00		2		
Nurse Practitioner	1.20	1.67	2.00				
PCS						43	6
Staff RN	39.31	1.26	49.67	11			
MHT	16.38	1.26	20.70	1			
Manager	1.00	1.26	1.26		1		
Assistant Manager	1.00	1.26	1.26		1		
Clerical	6.55	1.26	8.28	3			
Social Worker	11.47	1.26	14.49	5			
Psychiatrist	5.10	1.67	8.50	3			
Nurse Practitioner	1.75	1.67	2.92	1			
Common Staff: Inpatient							
MHT - 1 to 1	2.11	1.26	2.66	1			
Harm Reduction Specialist	1.17	1.26	1.48	0			
Administrative assistant	1.76	1.26	2.22	0.4			
Peer specialist	1.17	1.26	1.48	0.3			
Quality Manager	0.59	1.26	0.74	0.1			
House supervisor	2.46	1.26	3.10	0.5			
Hospitalist	1.64	1.67	2.73	0.4			
Patient Transport - MHT	1.17	1.26	1.48	0.3			
Clinical Nurse Specialist	0.59	1.26	0.74	0.1			
Common Staff: PCS							
MHT - 1 to 1	0.00	1.26	0.00	0.0			
Harm Reduction Specialist	1.00	1.26	1.26	0.2			
Administrative assistant	1.50	1.26	1.90	0.3			
Peer specialist	1.00	1.26	1.26	0.2			
Quality Manager	0.50	1.26	0.63	0.1			
House supervisor	2.10	1.26	2.65	0.5			
Hospitalist	0.00	1.67	0.00	0.0			
Patient Transport - MHT	1.00	1.26	1.26	0.2			
Clinical Nurse Specialist	0.50	1.26	0.63				
				89	16	148	19
Management Staff							
Chief Medical Officer	0.50	1.00	0.50		1		1
Clerical and Staffing Office						3	
Medical Director	0.50	1.00	0.50		1		1
Nurse Leader	1.00	1.00	1.00		1		2
Administrative Leader	1.00	1.00	1.00		1		1
				0	4		5
Pharmacy							
Pharmacist	1.64	1.26	2.07		1		2
Pharmacy tech	1.23	1.26	1.55	1		7	
				1	1	7	2
Patient Registration/Discharge							
Front Desk (both IP & OP)	4.91	1.26	6.21	2		1	
Floor Follow up (IP)	0.59	1.26	0.74	1		1	
Supervisor (both IP & OP)	1.17	1.26	1.48		1		1
Financial Consultant (both IP & OP)	1.17	1.26	1.48		1		1
Insurance Verification (IP)	1.17	1.26	1.48	1		1	1
Registration (OP only)	7.37	1.26	9.31	3		2	
				7	2	5	3
Security							
Security in PES	4.91	1.26	6.21	1		1	
Director/Spervisor							2
Security in front lobby	2.05	1.26	2.59	1		1	
Security in ambulance bay	4.91	1.26	6.21	1			
				3	0		
				6	0	2	2
Facilities							
Maintenance worker	1.76	1.26	2.22			1	1
				0	0	1	1
IT							
Application System Analyst	1.17	1.26	1.48	1			
Sr. Desktop Support Specialist	1.17	1.26	1.48	1		2	
Network Engineer	0.59	1.26	0.74	1		2	
				3	0	4	0
Housekeeping							
Floor Tech	1.17	1.26	1.48			1	2
Supply Tech	2.34	1.26	2.96	1		1	
Housekeeper	9.94	1.26	12.56				
				1	1		
Other							
Infection Control RN				0	0		1
Human Resources				0	0		1
Fiscal/Accounting/Business Office				0	0	2	
Volunteer Coordinator - see Admitting				0	1		
Interpreter - see Admitting Offices				0	1		
Legal				0	0	0	1
Switchboard						1	
QA				0	0	3	
Educator				0	0	4	1
Adjunctive Therapies						11	1
Laboratory			6.00				
Imaging			4.00				
Supply chain			4.00	2		2	1
Dietary			6.00		1	3	1
	337.24		454.49	2	3	26	7
Grand Total				109	27	185	38

Appendix K - Therapy Space Use and Hours

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				Hours Available per Day	Treatment Days Per Week	Treatment Hours per Week per Room	Number of Rooms	Average # of Patients in Room	Patient Treatment Hours/Week	Average Hours Treatment Available Per Patient Per Week Adolescent	Adult
Adult 18 and 24 Bed Units)											
Quiet Activity	3	80	240	4	5	20	3	1	60		
Visiting/Consult Room/Quiet Activity	7	120	840	4	5	20	7	1	140		
Dining Room	3	500	1,500	4	5	20	3	8	480		
Group Therapy	5	225	1,125	6	5	30	5	8	1,200		
Comfort Room	2	80	160	6	5	30	2	1	60		
Interview/Consult Room (neighborhood)	2	120	240	4	5	20	2	1	40		
Multi-Purpose Room	3	250	750	6	5	30	3	8	720		
			4,855						2,700		45
Adolescent (18 bed Unit)											
Visiting/Quiet/Consult Room	3	120	360	4	5	20	3	1	60		
Dining Room	1	450	450	4	5	20	1	8	160		
Quiet Activity	1	150	150	4	5	20	1	1	20		
Group Therapy	2	225	450	6	5	30	2	8	480		
Multi-Purpose Room	1	375	375	6	5	30	1	6	180		
Exercise Room	1	600	600	6	5	30	1	6	180		
Classroom	3	200	600	6	5	30	4	6	720		
Visiting	2	140	280	3	5	15	2	1	30		
Comfort/Sensory Room	3	100	300	6	5	30	3	1	90		
Interview/Consultation Rooms	1	120	120	6	5	30	1	1	30		
			3,685						1,950	108	
Therapy											
Gymnasium/Multi-Purpose Room	1	3,600	3,600	6	5	30	1	8	240	3	3
Exercise/Fitness Room	1	600	600	6	5	30	1	6	180	2	2
Movement Studio	1	600	600	6	5	30	1	6	180	2	2
Chapel Multi-purpose Room	1	450	450	6	5	30	1	6	180	2	2
Art Therapy Room	1	400	400	6	5	30	1	8	240	3	3
Greenhouse	1	250	250	6	5	30	1	4	120	2	2
ADL-Teaching Kitchen	1	200	200	6	5	30	1	4	120	2	2
Resource Library	1	220	220	6	5	30	1	4	120	2	2
			6,320						1,380	126	63

	Adolescent	Adult
On-Unit	108	45
Off-Unit	126	63
Total	234	108

Hours of treatment per patient per week supported by facilities

Appendix L - Construction Costs for Comparable Projects Adjusted for Geography and Inflation

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Psychiatric Hospital Database: Extractions for Milwaukee County
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7/3/15 10:51

100% Size/Efficiency Adjustment for Small Facility
1.031 Location Factor (Milwaukee, WI)
223.6 Projected Inflation Adjusted Historic Cost Index (Assumes 2017 bid date)
206.7 Mean's Historic Cost Index, January 2015

Name	Location	Regulatory Basis	Size (bgsf)	Floors	Beds	Single Bed to Double Bed Ratio	Construction Cost	Cost Basis	Sitework Value Included	Contingencies Included	LEED?	Cost Denomination	Year Complete	Cost/SF	Location Factor	Basis Year for Cost (Real or Projected Bid Date)	Historical Cost Index (at basis year)	Probable Cost for Target Site and Mid-Point of Construction	Construction Type	Comments	Per Bed (unadjusted)	Per Bed (adjusted for escalation and location)
Wake County Mental Health	Raleigh, NC	AIA Chapter 11	55,388	2	60	all single	$ 18,404,505	Final cost with all change orders.	$2,200,000 included	included	No	US	2011	$ 332	0.803	2009	180	$ 530	1	Appropriately configured and budgeted.	$ 306,741.75	$ 489,160
Memphis Mental Health Institute	Memphis, TN	AIA Chapter 7	103,000	3	75	1:24	$ 23,700,000	Construction Complete	$2,452,430 included	included	No	US	2006	$ 230	0.869	2005	151.6	$ 403	1	Bare bones, not appropriateley configured. Didn't employ some recommended security and safety features.	$ 316,000.00	$ 552,884
Riverview Psychiatric Hospital/AMHI *(as built)*	Augusta, Maine	AIA Chapter 11	127,000	2	92	all single	$ 23,000,000	Actual Construction Cost	included	Actual Construction Cost	No	US	2004	$ 181	0.923	2002	128.7	$ 351	2	Bare-bones and spartan...but has appropriate security. Some anti-ligature updates needs.	$ 250,000.00	$ 485,094
Spring Harbor Hospital	Portland, Maine	AIA Chapter 11	85,000	2	100		$ 20,000,000	GMP Price	included	GMP		US	2004	$ 235	0.968	2002	128.7	$ 435	2B	Essentially developed to same level of finish and durability as an SNF.	$ 200,000.00	$ 370,034
Logansport State Hospital	Logonsport, Indiana	AIA Chapter 11	113,000	1	126	1 to 3?	$ 22,048,973	Final cost with all change orders.	1,776,665	Actual Construction Cost with all change orders included.	No	US	2005	$ 195	0.89	2002	126.7	$ 399	?	Project details unknown Reputed to be fairly bare bones.	$ 174,991.85	$ 357,698
Rhode Island State Hospital,	Warwick, RI	FGI 2.1-2.5	106,991	3	140	83% single	$ 47,000,000	Final CD Estimate	included	included	No	US	2016 est	$ 439	1.08	2014	204.9	$ 458	1	Bare-bones and spartan...but has appropriate security and patient safety features.	$ 335,714.29	$ 349,679
Western Mental Health Institute	Bolivar, TN	AIA Chapter 11	159,600	3	150		$ 49,349,263	Cost w/change orders mid-poiunt of construction	$ 1,915,200	Design and Construction	Yes	US in planning	$	2007	$ 309	0.83	2007	169.4	$ 507	1A	Bare bones, but appropriateley configured. But still, spartan.	$ 328,995.09	$ 539,341
Kings County Phase IV	Brooklyn, NY	AIA Chapter 7	304,000	7	225	1 to 13	$ 120,000,000	TDK Gilbane, Final Cost	$ 2,140,493	5% for Bid/Construction	No	US	2007	$ 395	1.314	2005	152	$ 456	1	Appropriate levels of security and anti-ligature. VCT finishes and lay-in ceiling. Very simple floorplate and seven stories tall. Very little site work.	$ 533,333.33	$ 615,497
Bryce Hospital, Tuscaloosa, Alabama	Tuscaloosa, AL	FGI 2.1-2.5	251,763	2	268	18% single	$ 56,000,000	Bid w/o CM Fee Plus Change Orders	included	incuded	No	US	2013	$ 222	0.83	2011	185	$ 334	1A	Agressively economic.	$ 208,955.22	$ 313,667
Eastern State Hospital, Kentucky	Lexington, KY	FGI 2.1-2.5	313,641	3	278	37% single	$ 108,000,000	Final cost with all change orders.	included	incuded	Yes	US	2013	$ 344	0.9	2011	185	$ 477	1	Appropriately configured and budgeted. Note that 48 of the 278 beds are in less expensive RTF's	$ 388,489.21	$ 537,812
St. Elizabeth's	Washington, DC	AIA Chapter 11	448,190	3	297	?	$ 141,357,027	Construction Complete?	$7,219,000 included	included	No?	US	2009	$ 315	0.971	2006	162	$ 462	1	Project details unknown.	$ 475,949.59	$ 697,417
Massachussetts State Hospital	Worcester/Westborough, MA	AIA Chapter 11	403,223	3	320	all single	$ 258,666,331	Final cost with all change orders.	included	incuded	Yes	US	2012	$ 641	1.116	2009	180.1	$ 736	1A	BMW 7 series	$ 808,332.28	$ 926,996
Whitby Psychiatric Center	Whitby, Ontario	MoHLTC	500,000	2	325	11 to 14	$ 133,500,000	Final cost with all change orders.	included	included	No	Canadian $	1995	$ 267	1.109	1993	101.7	$ 546	1	Cadillac Fleetwood	$ 410,769.23	$ 839,482
Rochester Psychiatric Center	Rochester, NY	AIA Chapter 11	412,000	3	330	1 to 4	$ 67,883,008	Final cost with all change orders	2,960,000	Actual Final Construction Cost with all change orders included.	No	US	1995	$ 165	1.002	1993	101.7	$ 373	1A	Costs derived from final project cost and change order log. Excludes demolition project, temporary site utilities. Appropriate level of finishes and security. Anti-ligature upgrades would be needed today. Constant volume reheat system. Bid at absolutely the bottom of a desparate construction market in upstate NY.	$ 205,706.08	$ 465,291
North Carolina State Psychiatric Hospital: Butner	Butner, NC	AIA Chapter 11	463,500	2	429		$ 75,900,000	?	?	?	?	US	2009	$ 164	0.821	2004	143.7	$ 320	?	Fairly bare-bones. Did not use polycarbonate security windows. Opening has been delayed by problems.	$ 176,923.08	$ 345,661

$ 452 overall average
$ 493 probable average

Appendix M - Soft Costs to Be Added to Construction Cost to Calculate Project Costs

Soft Costs for Hospital Projects

18-Jun-15

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Percentage Based Fees

External Project Manager Staff and Overhead assume some internal)	1.0%	of construction costs
Architectural Fee	6.0%	of construction costs
MP Engineering Fee	2.4%	of construction costs
MP Commissioning Fee (Include leed costs)	0.6%	of construction costs
Electrical Engineering Fee	1.0%	of construction costs
Civil Engineering Fee	0.2%	of construction costs
Structural Engineering Fee	0.5%	of construction costs
Interior Design Fee	0.3%	of construction costs
Medical Equipment Planning Fee	0.4%	of construction costs
Master Plan/Predesign	0.5%	of construction costs
Preconstruction Studies including Peer Review, Constructability and Bid	0.7%	of construction costs
Cost Estimating including value analysis and Value Engineering	0.7%	of construction costs
Reimbursables	1.0%	of construction costs
Subtotal	15.2%	
Fee Contingency @ 10%	1.5%	
Total Fees	17%	

Lump Sum Fees/Costs

Permit Consulting	$	2.70	per sf
Air, Wind, Acoustic and Traffic permitting/studies	$	1.30	per sf
Food Service and Materials Handling	$	0.40	per sf
CON Fee (threshold of $20,000)	$	0.40	per sf
Signage and wayfinding	$	3.65	per sf
Land Acquisition		tbd	
Purchase of Buildings		tbd	
Debt Financing Expense		tbd	
MEP One Line As-Built Updates		tbd	
Moving	$	2.80	per sf
	$	11.25	
AdditionalFee Contingency @ 10%	$	1.12	
	$	12.37	2.6% of probable cost

Furniture, Equipment and Systems Costs

IS Infrastructure	$	5.50	per sf
IS Desktop (pc's, printers, phones, copiers, etc)	$	8.30	per sf
Furnishing and Equipment (incl security sys)	$	41.40	per sf
	$	55.20	11.6% of probable cost

31.0% Soft Costs w/FAMC FF&E Costs